

EXHIBIT E



P.O. BOX 5600
HARTFORD CT

06102

**WORKERS COMPENSATION
INSURANCE PLAN LETTER**

POLICY NUMBER:
(6JUB-4N42607-7-21)

EXPIRATION DATE 06-15-21

A/R (WCIP) #

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043

Dear Policyholder:

Enclosed is your renewal quotation based on the latest payroll classification information available to us. In addition, payrolls have been increased in accordance with our established inflationary guidelines.

Your renewal premium may require future adjustment as a result of changes in the Workers' Compensation insurance rates, surcharges, experience modification factors or other programs approved by your state.

IMPORTANT NOTICE

- All premiums billed under your expiring policy must be paid before your policy can be renewed. If any outstanding premiums have not been paid, please remit them immediately.
- If the payroll, classifications or other information displayed on the attached quotation are not what you anticipate during the coming year, please advise us immediately.
- Any request to change payrolls or other information should be submitted on your company letterhead with an explanation of the reasons for the change. Appropriate tax forms are required as supporting documentation for a payroll change request. The new premium deposit should be recalculated and payment received by the due date.
- In order to avoid a lapse in coverage, your renewal payment must be received by the expiration date shown on your bill. Depending on the plan requirements, if payment is not received by the expiration date, either the policy will be issued with a lapse in coverage or your premium check will be returned and no policy will be issued.
- In addition, this quotation may be affected by the following rating program approved for the Georgia Workers Compensation Insurance Plan:

LSRP (Loss Sensitive Rating Program) requires mandatory participation for qualifying insureds:
Employers with premium greater than \$250,000 cannot be afforded a guaranteed cost policy and will be subject to a retrospectively rated policy. Submission of your renewal deposit constitutes knowledge and acceptance of the Loss Sensitive Rating Plan to your policy.

- Requirements in Georgia provide that an advance notice of termination of coverage must be filed with the state Workers' Compensation insurance administration office. Therefore, if applicable, we have filed the termination notice with your state. If payment is received by the due date, we will rescind this notice.

- In accordance with the Georgia Workers' Compensation Assigned Risk Insurance Plan Chapter 120-2-38, all Georgia Assigned Risk policies will be subject to the Three Tier Rating Program. Your policy premium will be determined by using the appropriate rating plan group below. The regulation defines the following three rating groups:

"Group 1" means risks which have insufficient prior workers' compensation experience to be experience rated. Group 1 risks are subject to a Merit Rating Program.

"Group 2" means risks which are not Group 1 or Group 3 risks. The assigned risk manual rates shall apply to those risks assigned to Group 2.

"Group 3" means risks which have an experience rating modification greater than 1.0. The premium of Group 3 risks may be adjusted based on their loss experience upon approval of such rating program.

- Please be advised that Certificates of Insurance are term specific and will not be automatically carried over to your renewal term. If a Certificate of Insurance is required for the renewal term it must be requested.

PAYMENT OPTIONS:

The renewal deposit indicated with your quotation is based upon the payment plan that your prior policy was issued. Based upon the schedule below, if you qualify for a different payment basis and desire to change your option, please remit the appropriate deposit based upon the quoted estimated annual premium. The payment options in Georgia are:

<u>Estimated Annual Premium</u>	<u>Payment Basis</u>	<u>Minimum Deposit Percentage</u>	<u>Additional Payments During Year</u>
Less than \$5,000	Annual	100%	None
At least \$5,000	Semi-Annual	75%	One
At least \$10,000	Quarterly	50%	Three

If you have any questions, please contact your producer.

TRAVELERSTRAVELERS - RMD
P.O. BOX 5600
HARTFORD CT 06102-5600**PREMIUM NOTICE**

ASSIGNED RISK - WORKERS COMPENSATION INSURANCE

Date of Bill: 03-22-21
Policy Number: 4N426077PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043**DIRECT INQUIRIES TO:**TRAVELERS - RMD
P.O. BOX 5600
HARTFORD CT 06102-5600

1-800-443-4404

Amount Due	\$ 1620
Date Due	06-01-21
Expiration Date	06-15-21

PRODUCER: FOSTER AND ASSOCIATES

TRANSACTION DESCRIPTION	AMOUNT
-------------------------	--------

AMOUNT NEEDED FOR RENEWAL: \$ 1620

Your policy will expire on the expiration date if the renewal premium is not paid prior to the due date. If the required deposit is received by us within 60 days after policy expiration, your renewal will be effective the day after the U.S. postmark date appearing on the renewal deposit envelope or the day after electronic or telephonic submission. Monies received for deposit more than 60 days after the expiration date will be returned and the policy will not be renewed.

Renewal payments can be made electronically at www.travelers.com/expresspay, by phone at 1-800-443-4404, or by detaching the payment stub and mailing to the return address below.

RETURN PAYMENT STUBPayment From:

PRIME PAINTERS LLC

TRAVELERS - RMD
DEPT 98699
PO BOX 660333
DALLAS TX 75266-0333

*Make checks payable to TRAVELERS - RMD
and write your policy number on the check.*

Policy Number: 4N426077

EXPIRATION DATE
06-15-21
DATE DUE
06-01-21
AMOUNT DUE
\$ 1620
AMOUNT ENCLOSED



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THIS IS A QUOTE, NOT A POLICY

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

QUOTE PROFILE - VERSION 01

POLICY NUMBER: (6JUB-4N42607-7-21)

RENEWAL OF (6JUB-4N42607-7-20)

INSURED'S NAME AND ADDRESS

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043

WORKERS COMPENSATION
INSURANCE PLAN

A/R (WCIP) # GA

POLICY PERIOD FROM: 06-15-21 TO 06-15-22

TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	\$	1460
PREMIUM DISCOUNT		NONE
0900-10 EXPENSE CONSTANT		160
TERRORISM		NONE
TOTAL ESTIMATED PREMIUM		1620
DEPOSIT AMOUNT DUE		1620MP

Employer's Liability BI Limit: \$ 1000000 Each Accident
1000000 Policy Limit
1000000 Each Employee

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Adjustments of Premiums shall be made **ANNUALLY**

***** Deposit Amount Due: \$ 1620 *****

POLICY NUMBER: (6JUB-4N42607-7-21)

DATE OF ISSUE: 03-22-21 WC

ST ASSIGN: GA

OFFICE: RMD GA POOL 775

PRODUCER: FOSTER AND ASSOCIATES 72PKK



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

QUOTE PROFILE

POLICY NUMBER: (6JUB-4N42607-7-21)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-GA

INSURED'S NAME: PRIME PAINTERS LLC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 563794723 ENTITY CD 001				
PRIME PAINTERS LLC				
1924 A COLLINS HILL RD				
LAWRENCEVILLE, GA 30043				
SIC CODE: 1721 NAICS: 238320				
PAINTING NOC & SHOP OPERATIONS, DRIVERS	5474	IF ANY	35.76	

1.10% INCREASED LIMITS	\$	NONE
ADD FOR INCREASED LIMITS MINIMUM (9848)		120
.875 MERIT RATING MODIFICATION (9885)		15
ADD FOR POLICY MINIMUM		1355
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1460
EXPENSE CONSTANT(0900)		160
0.0100 TERRORISM (9740)		INCL
0.0100 CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		INCL
TOTAL ESTIMATED PREMIUM		1620
DEPOSIT AMOUNT DUE		1620

DATE OF ISSUE: 03-22-21 WC

ST ASSIGN: GA

SCHEDULE NO: 1 OF LAST



P.O. BOX 5600
HARTFORD CT

06102

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: (6JUB-4N42607-7-21)

**NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR
GEORGIA WORKERS' COMPENSATION INDEMNITY AND MEDICAL
BENEFITS**

Georgia Policyholders:

Georgia law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for indemnity and medical benefits and applies separately to each accident during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of \$100 and a maximum of \$2,500 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. You should: (1) Retain your copy for your records; (2) Send a copy to your producer to keep him/her informed of your intention; and (3) Complete and return a copy to the carrier within sixty (60) days after the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available by choosing this option, please contact your producer.

Item #1: HAZARD GROUP: _____

Item #2:

Premium Reduction Percentage
HAZARD GROUPS

<u>DEDUCTIBLE PER ACCIDENT</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>
\$ 100	0.6%	0.5%	0.4%	0.3%	0.2%	0.1%	0.1%
\$ 200	1.1%	0.9%	0.8%	0.6%	0.4%	0.3%	0.3%
\$ 300	1.6%	1.3%	1.1%	0.9%	0.6%	0.4%	0.4%
\$ 400	2.0%	1.6%	1.4%	1.1%	0.8%	0.5%	0.5%
\$ 500	2.4%	2.0%	1.7%	1.3%	1.0%	0.6%	0.6%
\$ 1,000	3.8%	3.3%	2.9%	2.2%	1.6%	1.1%	1.0%
\$ 1,500	5.0%	4.3%	3.7%	3.0%	2.2%	1.5%	1.4%
\$ 2,000	5.9%	5.1%	4.5%	3.6%	2.7%	1.9%	1.8%
\$ 2,500	6.7%	5.8%	5.1%	4.1%	3.1%	2.2%	2.1%



P.O. BOX 5600
HARTFORD CT

06102

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: (6JUB-4N42607-7-21)

Yes, I want a deductible of \$ _____ applied to indemnity and medical benefits under the Georgia Workers' Compensation Law. I understand that in accordance with the Georgia Law, I have the option of modifying the above deductible program choice at the time of renewal of my Workers Compensation policy.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: THE TRAVELERS INSURANCE COMPANIES

DATE OF ISSUE: 03-22-21

W10N2C21



Terrorism Risk Insurance Program Reauthorization Act Disclosure

The federal Terrorism Risk Insurance Act of 2002, as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2019 ("TRIA"), establishes a program under which the Federal Government may partially reimburse "Insured Losses" (as defined in TRIA) caused by "Acts Of Terrorism" (as defined in TRIA). "Act Of Terrorism" is defined in Section 102(1) of TRIA to mean any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, as meeting all of the following requirements:

- a. The act is an act of terrorism
- b. The act is violent or dangerous to human life, property, or infrastructure
- c. The act resulted in damage within the United States, or outside the United States in the case of the premises of United States missions or certain air carriers or vessels.
- d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

The Federal Government's share of compensation for such Insured Losses is established by TRIA and is a percent of such Insured Losses in excess of each Insurer's "Insurer Deductible" (as defined in TRIA). For the period beginning January 1, 2021 and ending on December 31, 2027, if the aggregate industry Insured Losses occurring in any calendar year exceed \$200,000,000 million, the United States Government will pay 80% of our Insured Losses that exceed our Insurer Deductible.

In no event, however, will the Federal Government be required to pay any portion of the amount of such Insured Losses occurring in a calendar year that in the aggregate exceeds \$100,000,000.000, nor will any Insurer be required to pay any portion of such amount provided that such Insurer has met its Insurer Deductible. Therefore, if such Insured Losses occurring in a calendar year exceed \$100,000,000.00 0 in the aggregate, the amount of any payments by the Federal Government and any coverage provided by this policy for losses caused by Acts Of Terrorism may be reduced.

The charge for such Insured Losses for Workers Compensation and Employers' Liability coverage is an additional premium, which is reflected in the premium schedule and does not include any charge for the portion of such Insured Losses covered by the Federal Government under TRIA.

Coverage	Included Charge For Insured Losses
Workers Compensation and Employers Liability	See Workers Compensation and Employers Liability Premium Schedule

Note – Terrorism premium charges are subject to change at any time based on state regulatory action.

IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website:

http://www.travelers.com/w32c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183

TRAVELERS - RMD
DEPT 98699
PO BOX 660333
DALLAS TX 75266-0333

PREMIUM NOTICE

ASSIGNED RISK-WORKERS COMPENSATION INSURANCE

Date of Bill: 03-22-21
Policy Number: 4N426077

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043

DIRECT INQUIRIES TO:

TRAVELERS - RMD
P.O. BOX 5600
HARTFORD CT 06102-5600

1-800-443-4404

Amount Due	\$ 1620
Date Due	06-01-21
Expiration Date	06-15-21

PRODUCER: FOSTER AND ASSOCIATES

TRANSACTION DESCRIPTION	AMOUNT
-------------------------	--------

AMOUNT NEEDED FOR RENEWAL: \$ 1620

YOUR POLICY WILL EXPIRE ON THE EXPIRATION DATE IF THE RENEWAL PREMIUM IS NOT PAID PRIOR TO THE DUE DATE. IF THE REQUIRED DEPOSIT IS RECEIVED BY US WITHIN 60 DAYS AFTER POLICY EXPIRATION, YOUR RENEWAL WILL BE EFFECTIVE THE DAY AFTER THE U.S. POSTMARK DATE APPEARING ON THE RENEWAL DEPOSIT ENVELOPE OR THE DAY AFTER ELECTRONIC OR TELEPHONIC SUBMISSION. MONIES RECEIVED FOR DEPOSIT MORE THAN 60 DAYS AFTER THE EXPIRATION DATE WILL BE RETURNED AND THE POLICY WILL NOT BE RENEWED.

Doc Type |||||

TRAVELERS - RMD
P.O. BOX 5600
HARTFORD CT 06102-5600

Date: 06-01-21

Policy Number: (6JUB-4N42607-7-21)

Current Policy Expiration Date: 06-15-22

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043

REMINDER – FAILURE TO PAY RENEWAL QUOTATION PREMIUM WILL RESULT IN TERMINATION OF COVERAGE

Dear Policyholder,

Several weeks ago, you received our renewal offer. We want to remind you that your current insurance policy term is expiring and failure to remit the required renewal premium by the policy expiration date will result in the lapse of your workers' compensation coverage.

For your convenience we have included a copy of our earlier renewal quotation.

Where required, the advanced notice of termination of coverage has already been filed.

If you have already paid your renewal deposit premium, **please disregard this notice**. If you have not paid your renewal deposit premium, please (a) remit the required deposit premium prior to the expiration date of your current policy to prevent termination of coverage, or (b) contact your producer to secure other workers' compensation insurance.

Thank you for your cooperation.

CC: FOSTER AND ASSOCIATES
3100 BRECKINRIDGE BLVD STE 510

DULUTH

GA 300967507



P.O. BOX 5600
HARTFORD CT

06102

**WORKERS COMPENSATION
INSURANCE PLAN LETTER**

POLICY NUMBER:
(6JUB-4N42607-7-21)

EXPIRATION DATE 06-15-21

A/R (WCIP) #

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
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Employers with premium greater than \$250,000 cannot be afforded a guaranteed cost policy and will be subject to a retrospectively rated policy. Submission of your renewal deposit constitutes knowledge and acceptance of the Loss Sensitive Rating Plan to your policy.

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- Please be advised that Certificates of Insurance are term specific and will not be automatically carried over to your renewal term. If a Certificate of Insurance is required for the renewal term it must be requested.

PAYMENT OPTIONS:

The renewal deposit indicated with your quotation is based upon the payment plan that your prior policy was issued. Based upon the schedule below, if you qualify for a different payment basis and desire to change your option, please remit the appropriate deposit based upon the quoted estimated annual premium. The payment options in Georgia are:

<u>Estimated Annual Premium</u>	<u>Payment Basis</u>	<u>Minimum Deposit Percentage</u>	<u>Additional Payments During Year</u>
Less than \$5,000	Annual	100%	None
At least \$5,000	Semi-Annual	75%	One
At least \$10,000	Quarterly	50%	Three

If you have any questions, please contact your producer.

TRAVELERSTRAVELERS - RMD
P.O. BOX 5600
HARTFORD CT 06102-5600**PREMIUM NOTICE**

ASSIGNED RISK - WORKERS COMPENSATION INSURANCE

Date of Bill: 06-01-21
Policy Number: 4N426077PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043**DIRECT INQUIRIES TO:**TRAVELERS - RMD
P.O. BOX 5600
HARTFORD CT 06102-5600

1-800-443-4404

Amount Due	\$ 1620
Date Due	06-15-21
Expiration Date	06-15-21

PRODUCER: FOSTER AND ASSOCIATES

TRANSACTION DESCRIPTION	AMOUNT
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AMOUNT NEEDED FOR RENEWAL: \$ 1620

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Renewal payments can be made electronically at www.travelers.com/expresspay, by phone at 1-800-443-4404, or by detaching the payment stub and mailing to the return address below.

RETURN PAYMENT STUBPayment From:

PRIME PAINTERS LLC

TRAVELERS - RMD
DEPT 98699
PO BOX 660333
DALLAS TX 75266-0333

*Make checks payable to TRAVELERS - RMD
and write your policy number on the check.*

Policy Number: 4N426077

EXPIRATION DATE
06-15-21
DATE DUE
06-15-21
AMOUNT DUE
\$ 1620
AMOUNT ENCLOSED



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THIS IS A QUOTE, NOT A POLICY

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

QUOTE PROFILE - VERSION 01

POLICY NUMBER: (6JUB-4N42607-7-21)

RENEWAL OF (6JUB-4N42607-7-20)

INSURED'S NAME AND ADDRESS

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043

WORKERS COMPENSATION
INSURANCE PLAN

A/R (WCIP) # GA

POLICY PERIOD FROM: 06-15-21 TO 06-15-22

TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	\$	1460
PREMIUM DISCOUNT		NONE
0900-10 EXPENSE CONSTANT		160
TERRORISM		NONE
TOTAL ESTIMATED PREMIUM		1620
DEPOSIT AMOUNT DUE		1620MP

Employer's Liability BI Limit: \$ 1000000 Each Accident
1000000 Policy Limit
1000000 Each Employee

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Adjustments of Premiums shall be made **ANNUALLY**

***** Deposit Amount Due: \$ 1620 *****

POLICY NUMBER: (6JUB-4N42607-7-21)

DATE OF ISSUE: 06-01-21 WC

ST ASSIGN: GA

OFFICE: RMD GA POOL 775

PRODUCER: FOSTER AND ASSOCIATES 72PKK



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

QUOTE PROFILE

POLICY NUMBER: (6JUB-4N42607-7-21)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-GA

INSURED'S NAME: PRIME PAINTERS LLC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 563794723 ENTITY CD 001				
PRIME PAINTERS LLC				
1924 A COLLINS HILL RD				
LAWRENCEVILLE, GA 30043				
SIC CODE: 1721 NAICS: 238320				
PAINTING NOC & SHOP OPERATIONS, DRIVERS	5474	IF ANY	35.76	

1.10% INCREASED LIMITS	\$	NONE
ADD FOR INCREASED LIMITS MINIMUM (9848)		120
.875 MERIT RATING MODIFICATION (9885)		15
ADD FOR POLICY MINIMUM		1355
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1460
EXPENSE CONSTANT(0900)		160
0.0100 TERRORISM (9740)		INCL
0.0100 CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		INCL
TOTAL ESTIMATED PREMIUM		1620
DEPOSIT AMOUNT DUE		1620

DATE OF ISSUE: 06-01-21 WC

ST ASSIGN: GA

SCHEDULE NO: 1 OF LAST



P.O. BOX 5600
HARTFORD CT

06102

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: (6JUB-4N42607-7-21)

**NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR
GEORGIA WORKERS' COMPENSATION INDEMNITY AND MEDICAL
BENEFITS**

Georgia Policyholders:

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To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

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If you decide that you do not want the deductible to apply, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available by choosing this option, please contact your producer.

Item #1: HAZARD GROUP: _____

Item #2:

Premium Reduction Percentage
HAZARD GROUPS

<u>DEDUCTIBLE PER ACCIDENT</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>
\$ 100	0.6%	0.5%	0.4%	0.3%	0.2%	0.1%	0.1%
\$ 200	1.1%	0.9%	0.8%	0.6%	0.4%	0.3%	0.3%
\$ 300	1.6%	1.3%	1.1%	0.9%	0.6%	0.4%	0.4%
\$ 400	2.0%	1.6%	1.4%	1.1%	0.8%	0.5%	0.5%
\$ 500	2.4%	2.0%	1.7%	1.3%	1.0%	0.6%	0.6%
\$ 1,000	3.8%	3.3%	2.9%	2.2%	1.6%	1.1%	1.0%
\$ 1,500	5.0%	4.3%	3.7%	3.0%	2.2%	1.5%	1.4%
\$ 2,000	5.9%	5.1%	4.5%	3.6%	2.7%	1.9%	1.8%
\$ 2,500	6.7%	5.8%	5.1%	4.1%	3.1%	2.2%	2.1%



P.O. BOX 5600
HARTFORD CT

06102

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: (6JUB-4N42607-7-21)

Yes, I want a deductible of \$ _____ applied to indemnity and medical benefits under the Georgia Workers' Compensation Law. I understand that in accordance with the Georgia Law, I have the option of modifying the above deductible program choice at the time of renewal of my Workers Compensation policy.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: THE TRAVELERS INSURANCE COMPANIES

DATE OF ISSUE: 06-01-21

W10N2C21



Terrorism Risk Insurance Program Reauthorization Act Disclosure

The federal Terrorism Risk Insurance Act of 2002, as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2019 ("TRIA"), establishes a program under which the Federal Government may partially reimburse "Insured Losses" (as defined in TRIA) caused by "Acts Of Terrorism" (as defined in TRIA). "Act Of Terrorism" is defined in Section 102(1) of TRIA to mean any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, as meeting all of the following requirements:

- a. The act is an act of terrorism
- b. The act is violent or dangerous to human life, property, or infrastructure
- c. The act resulted in damage within the United States, or outside the United States in the case of the premises of United States missions or certain air carriers or vessels.
- d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

The Federal Government's share of compensation for such Insured Losses is established by TRIA and is a percent of such Insured Losses in excess of each Insurer's "Insurer Deductible" (as defined in TRIA). For the period beginning January 1, 2021 and ending on December 31, 2027, if the aggregate industry Insured Losses occurring in any calendar year exceed \$200,000,000 million, the United States Government will pay 80% of our Insured Losses that exceed our Insurer Deductible.

In no event, however, will the Federal Government be required to pay any portion of the amount of such Insured Losses occurring in a calendar year that in the aggregate exceeds \$100,000,000.000, nor will any Insurer be required to pay any portion of such amount provided that such Insurer has met its Insurer Deductible. Therefore, if such Insured Losses occurring in a calendar year exceed \$100,000,000.00 0 in the aggregate, the amount of any payments by the Federal Government and any coverage provided by this policy for losses caused by Acts Of Terrorism may be reduced.

The charge for such Insured Losses for Workers Compensation and Employers' Liability coverage is an additional premium, which is reflected in the premium schedule and does not include any charge for the portion of such Insured Losses covered by the Federal Government under TRIA.

Coverage	Included Charge For Insured Losses
Workers Compensation and Employers Liability	See Workers Compensation and Employers Liability Premium Schedule

Note – Terrorism premium charges are subject to change at any time based on state regulatory action.

IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website:

http://www.travelers.com/w32c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183

TRAVELERS - RMD
DEPT 98699
PO BOX 660333
DALLAS TX 75266-0333

PREMIUM NOTICE

ASSIGNED RISK-WORKERS COMPENSATION INSURANCE

Date of Bill: 06-01-21
Policy Number: 4N426077

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043

DIRECT INQUIRIES TO:

TRAVELERS - RMD
P.O. BOX 5600
HARTFORD CT 06102-5600

1-800-443-4404

Amount Due	\$ 1620
Date Due	06-15-21
Expiration Date	06-15-21

PRODUCER: FOSTER AND ASSOCIATES

TRANSACTION DESCRIPTION	AMOUNT
-------------------------	--------

AMOUNT NEEDED FOR RENEWAL: \$ 1620

YOUR POLICY WILL EXPIRE ON THE EXPIRATION DATE IF THE RENEWAL PREMIUM IS NOT PAID PRIOR TO THE DUE DATE. IF THE REQUIRED DEPOSIT IS RECEIVED BY US WITHIN 60 DAYS AFTER POLICY EXPIRATION, YOUR RENEWAL WILL BE EFFECTIVE THE DAY AFTER THE U.S. POSTMARK DATE APPEARING ON THE RENEWAL DEPOSIT ENVELOPE OR THE DAY AFTER ELECTRONIC OR TELEPHONIC SUBMISSION. MONIES RECEIVED FOR DEPOSIT MORE THAN 60 DAYS AFTER THE EXPIRATION DATE WILL BE RETURNED AND THE POLICY WILL NOT BE RENEWED.

Doc Type |||||

SAFETY SERVICES

Notice to policy recipient: If you are not the person directly responsible for the accident prevention activities for your company, please direct this Safety Services notice to the person that is directly responsible for them.

SAFETY IS OUR CONCERN

Thank you for purchasing your insurance from one of the writing companies owned or managed by The Travelers Companies, Inc. We appreciate your business and welcome the opportunity to be of service.

An important part of that service concerns safety and accident prevention. Travelers Risk Control has an extensive staff of safety and loss prevention professionals assisting customers across the country and around the world. We have one of the largest Risk Control departments in the industry, and our scale allows us to apply the right resource at the right time to meet customer needs.

We have a wide range of industry-specific experience, which includes manufacturing, construction, wholesale and retail businesses, service organizations, technology-related business, the oil and gas industry, the public sector and others.

Following are some examples of available safety services:

Accident Prevention – Our staff can help you identify present and potential hazards within your operations, premises and equipment, and recommend solutions for reducing or eliminating these hazards.

Analysis of Accident Causes – Our REACT accident investigation program can assist you in determining root causes of accidents and help you prevent recurrences.

Safety Consultations – Our consultants can assist you with solutions in specialized areas such as ergonomics, industrial hygiene and fleet safety.

These services are available upon request. See the remainder of this document for the Travelers' Risk Control office nearest you. These phone numbers should not be used for questions regarding your policy or claims.

Industrial Hygiene/Health Services – Travelers has an AIHA accredited lab to analyze air samples taken by our IH Specialists, or by you, through our Pump Loan program to help you identify potential exposures to occupational illnesses.

Safety Literature and Digital Media – Our Risk Control customer website has hundreds of resources including checklists, sample programs, self-assessments, instructional videos and other safety and health related tools.

Safety Training – We offer face-to-face classroom courses, as well as distance learning and online training programs on a variety of safety and risk management topics in order to provide flexibility for your safety training needs.

Return-To-Work Coordination – We have consultants who specialize in post injury management that can assist you with developing or enhancing a return-to-work program, along with other aspects of our Corridor of Care® post injury process.

Please note: For ALL loss control assistance requests, please contact your local office directly, which is listed on one of the following pages.

SAFETY IS YOUR CONCERN

At Travelers, we are committed to helping protect your business. Travelers Risk Control has the experience, resources and capabilities to provide a range of safety services Onsite, Online and On-Demand. As our customer, you have access to hundreds of safety resources that cover an array of safety and risk management topics to help you control hazards and reduce risks of injury or illness. You can access these resources by logging in at www.travelers.com. Not registered? Select "Log In" and then "Register Now" to register for MyTravelers for Business.

Examples of what you will find include:

- Safety checklists, sample programs and self-assessments.
- Safety training offerings including classroom, and online.
- Additional safety products and services

These resources can help you improve your workplace safety practices.

Contact Us

For more information, please visit travelers.com/riskcontrol or contact your local Travelers office.

The loss of a key employee due to an injury can seriously impact your business. We can help you to understand the types of accidents that may occur in your business and the steps you can take to help prevent them.

Please call these numbers**FOR SAFETY SERVICES ONLY****For all other inquiries please contact your agent, underwriter or claim representative****ALABAMA
Birmingham**

3000 Riverchase Galleria
Ste. 600
Birmingham, AL 35244
Risk Control: 1-800-973-9215
Claims: 1-800-238-6214

ALASKA**Portland, OR**

4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
Risk Control: 1-800-973-9215

ARIZONA**Phoenix**

2401 W Peoria Ave., Suite 130
Phoenix, AZ 85029
Risk Control: 1-800-973-9215

ARKANSAS**Kansas City, KS**

7465 West 132nd, Suite 400
Overland Park, KS 66213
Risk Control: 1-800-973-9215

CALIFORNIA**Diamond Bar**

21688 Gateway Center Drive
P.O. Box 6512
Diamond Bar, CA 91765-8512
Risk Control: 1-800-973-9215
Claims: (909) 612-3000

CALIFORNIA**Glendale**

655 N. Central Avenue, Suite 1600
Glendale, CA 91203
Risk Control: 1-800-973-9215
Claims: (909) 612-3000

CALIFORNIA**Irvine**

3333 Michelson Dr. City Blvd. W
Suite 1000
Irvine, CA 92612
Risk Control: 1-800-973-9215

CALIFORNIA**Los Angeles**

888 South Figueroa St., Ste. 500
Los Angeles, CA 90017
Risk Control: 1-800-973-9215
Claims: (909) 612-3000

CALIFORNIA**Sacramento**

11070 White Rock Road, Suite 130
Rancho Cordova, CA 95670
Risk Control: 1-800-973-9215
Claims: (800) 727-3995

CALIFORNIA**San Diego**

9325 Sky Park Court, Suite 220
San Diego, CA 92123
Risk Control: 1-800-973-9215

CALIFORNIA**Walnut Creek**

401 Lennon Lane, Suite 100
Walnut Creek, CA 94598
Risk Control: 1-800-973-9215
Claims: (800) 842-7354

COLORADO**Denver**

6060 S. Willow Dr. #300
Greenwood Village, CO 80111
Risk Control: 1-800-973-9215
Claims: 720-200-8100

CONNECTICUT**Hartford**

300 Windsor Street
Hartford, CT 06120
Risk Control: 1-800-973-9215
Claims: 1 (877) 828-4110

DELAWARE**Philadelphia, PA**

10 Sentry Parkway, Suite 300
Blue Bell, PA 19422
Risk Control: 1-800-973-9215
Claims: 1-800-368-3562

DISTRICT OF COLUMBIA**Washington, DC**

14200 Park Meadow Dr.
Chantilly, VA 20151
Risk Control: 1-800-973-9215
Claims: 1-800-368-3562

FLORIDA**Orlando**

2420 Lakemont Dr
Orlando, FL 32814
Risk Control: 1-800-973-9215
Claims: 407-388-2400

GEORGIA**Atlanta**

1000 Windward Concourse
Alpharetta, GA 30005
Risk Control: 1-800-973-9215
Claims: 800-238-6214

HAWAII**Irvine, CA**

3333 Michelson Drive City Blvd. W
Suite 1000
Irvine, CA 92612
Risk Control: 1-800-973-9215

IDAHO**Sacramento, CA**

11070 White Rock Rd, Suite 130
Rancho Cordova, CA 95670
Risk Control: 1-800-973-9215
Claim: (800) 727-3995

ILLINOIS**Chicago**

161 N Clark St.
Suite 900
Chicago, IL 60601
Risk Control: 1-800-973-9215
Claims: 800-842-6172

ILLINOIS**Naperville**

215 Shuman Boulevard
P.O. Box 3208
Naperville, IL 60566
Risk Control: 1-800-973-9215
Claims: 800-842-6172

INDIANA**Indianapolis**

Suite 300
280 East 96th Street
Indianapolis, IN 46240
Risk Control: 1-800-973-9215
Claims: 800-238-6210

IOWA**Des Moines**

7101 Vista Dr.
West Des Moines, IA 50266-9313
Risk Control: 1-800-973-9215
Claims: 800-255-5072

KANSAS**Kansas City**

7465 West 132nd, Suite 400
Overland Park, KS 66213
Risk Control: 1-800-973-9215

KENTUCKY**Louisville**

Suite 150
303 N Hurstbourne Pkwy
Louisville, KY 40222
Risk Control: 1-800-973-9215
Claims: 800-238-6210

LOUISIANA**New Orleans**

3838 N. Causeway, Suite 2700
Metairie, LA 70002
P.O. Box 61479
New Orleans, LA 70161-1479
Risk Control: 1-800-973-9215
Claims: 800-842-2556

MAINE**Portland, ME**

207 Larrabee Road, Suite 3
Westbrook, ME 04092
Risk Control: 1-800-973-9215

MARYLAND**Blue Bell, PA**

10 Sentry Parkway, Suite 300
Blue Bell, PA 19422
Risk Control: 1-800-973-9215
Claims: 1-800-368-3562

MASSACHUSETTS**Boston**

100 Summer Street, Suite 201A
Boston, MA 02110
Risk Control: 1-800-973-9215
Claims: 800-832-7839

MASSACHUSETTS**Hudson**

1 Cabot Road
Suite 250
Hudson, MA 01749
Risk Control: 1-800-973-9215
Claims: 800-832-7839

Please call these numbers

FOR SAFETY SERVICES ONLY**For all other inquiries please contact your agent, underwriter or claim representative****MASSACHUSETTS****Braintree**

350 Granite Street
Suite 1201
Braintree, MA 02184
Risk Control: 1-800-973-9215
Claims: 800-832-7839

MICHIGAN**Grand Rapids**

625 Kenmoor Ave
Suite 213
Grand Rapids, MI 49546
Risk Control: 1-800-973-9215
Claims: 800-238-6210

MICHIGAN**Troy**

1441 W. Long Lake Rd., Ste. 300
Troy, MI 48098
Risk Control: 1-800-973-9215
Claims: 800-238-6210

MINNESOTA**St. Paul**

385 Washington St., MC 104P
St. Paul, MN 55102
Risk Control: 1-800-973-9215
Claims: 800-842-3073

MISSISSIPPI**Jackson**

1080 River Oaks Dr
Ste B-200
Flowood, MS 39232
Risk Control: 1-800-973-9215
Claims: 1-800-342-4064

MISSOURI**St. Louis**

940 West Port Plaza, Suite 270
St. Louis, MO 63146
Risk Control: 1-800-973-9215
Claims: 800-842-9621

Kansas City

7465 W 132nd, Suite 400
Overland Park, KS 66213
Risk Control: 1-800-973-9215
Claims: 800-255-5072

Missouri Workers'**Compensation Plan (MWCP)**

4801 Main Street, Suite 350
Kansas City, MO 64112
Risk Control: 1-800-973-9215

MONTANA**Sacramento, CA**

11070 White Rock Rd, Suite 130
Rancho Cordova, CA 95670
Risk Control: 1-800-973-9215
Claims: (800) 727-3995

NEBRASKA**Omaha**

11516 Miracle Hills Dr., St. 400
Omaha, NE 68154
Risk Control: 1-800-973-9215
Claims: 800-255-5072

NEVADA**Las Vegas**

7450 Arroyo Crossing Pkwy
Suite 200
Las Vegas, NV 89113
Risk Control: 1-800-973-9215
Claims: 702-479-4200

NEW HAMPSHIRE**Portland, ME**

207 Larrabee Road, Suite 3
Westbrook, ME 04092
Risk Control: 1-800-973-9215

NEW JERSEY**Morristown**

445 South Street
Morristown, NJ 07960
Risk Control: 1-800-973-9215
Claims: 1-800-842-2475

NEW JERSEY**Marlton**

Lake Center Exec Park Building 30
Suite 110
Marlton, NJ 08053
Risk Control: 1-800-973-9215
Claims: 800-842-2475

NEW MEXICO**Phoenix**

2401 W Peoria Ave., Suite 130
Phoenix, AZ 85029
Risk Control: 1-800-973-9215
Claims: 602-861-8600

NEW YORK**Albany**

900 Watervliet-Shaker Road
Albany, NY 12205
Risk Control: 1-800-973-9215
Claims: 800-842-2475

NEW YORK**Buffalo**

60 Lakefront Blvd.
P.O. Box 242
Buffalo, NY 14240-0242
Risk Control: 1-800-973-9215
Claims: 800-842-2475

NEW YORK**Melville**

3 Huntington Quadrangle
Melville, NY 11747
Risk Control: 1-800-973-9215
Claims: 800-842-2475

NEW YORK**New York**

485 Lexington Ave.
New York, NY 10017-2630
Risk Control: 1-800-973-9215
Claims: 1-800-842-2475

NEW YORK**Rochester**

75 Town Centre Drive
P.O. Box 23235
Rochester, NY 14692-3235
Risk Control: 1-800-973-9215
Claims: 1-800-842-2475

NEW YORK**Syracuse**

440 South Warren Street
P.O. Box 4963
Syracuse, NY 13221-4963
Risk Control: 1-800-973-9215
Claims: 800-842-2475

NORTH CAROLINA**Charlotte**

11440 Carmel Commons Blvd.
Suite 400
Charlotte, NC 28226
Risk Control: 1-800-973-9215
Claims: (704) 544-3500

NORTH CAROLINA**Raleigh**

4504 Emperor Blvd.
Durham, NC 27703
Risk Control: 1-800-973-9215
Claims: (704) 544-3500

NORTH DAKOTA**St. Paul, MN**

385 Washington St., MC 104P
St. Paul, MN 55102
Risk Control: 1-800-973-9215
Claims: 800-842-3073

OHIO**Cincinnati**

Baldwin Center, Suite 500
625 Eden Park Drive
Cincinnati, OH 45202
Risk Control: 1-800-973-9215
Claims: 800-238-6210

OHIO**Cleveland**

6150 Oak Tree Blvd., Suite 400
Independence, OH 44131
Risk Control: 1-800-973-9215
Claims: 800-238-6210

OKLAHOMA**Tulsa**

9820 East 41st St., Suite 401
P.O. Box 3510
Tulsa, OK 74101
Risk Control: 1-800-973-9215

OREGON**Portland**

4000 SW Kruse Way Place,
Building 1, Suite 255
Lake Oswego, OR 97035
Risk Control: 1-800-973-9215
Claims: 800-698-6883

PENNSYLVANIA**Philadelphia**

10 Sentry Parkway, Suite 300
Blue Bell, PA 19422
Risk Control: 1-800-973-9215
Claims: 800-832-0606

PENNSYLVANIA**Pittsburgh**

112 Washington Place, Suite 910
Pittsburgh, PA 15219
Risk Control: 1-800-973-9215
Claims: (412) 338-3000

Please call these numbers

FOR SAFETY SERVICES ONLY

For all other inquiries please contact your agent, underwriter or claim representative

PENNSYLVANIA

Reading

1105 Berkshire Blvd.
P.O. Box 13426
Wyomissing, PA 19610
Risk Control: 1-800-973-9215
Claims: 800-832-0606

RHODE ISLAND

Braintree

350 Granite Street
Suite 1201
Braintree, MA 02184
Risk Control: 1-800-973-9215
Claims: 800-832-7839

SOUTH CAROLINA

Charlotte

11440 Carmel Commons Blvd.
P.O. Box 473500
Charlotte, NC 28247-3500
Risk Control: 1-800-973-9215
Claims: 704-544-3500

SOUTH DAKOTA

St. Paul, MN

385 Washington St.
St. Paul, MN 55102
Risk Control: 1-800-973-9215
Claims: 800-842-3073

TENNESSEE

Franklin

6640 Carothers Pkwy, Suite 300
Franklin, TN 37067
Risk Control: 1-800-973-9215
Claims: (615) 660-6000

TEXAS

Dallas

1301 E Collins Blvd., Suite 300
Richardson, TX 75081
Risk Control: 1-800-973-9215
Claims: 214-570-6000

TEXAS

Houston

4650 Westway Park Blvd., Suite 350
Houston, TX 77041
Risk Control: 1-800-973-9215
Claims: 800-235-3610

UTAH

Denver, CO

6060 S. Willow Drive#300
Greenwood Village, CO 80111
Risk Control: 1-800-973-9215
Claims: 800-453-3025

VERMONT

Hartford, CT

300 Windsor Street
Hartford, CT 06120
Risk Control: 1-800-973-9215
Claims: (800) 422-3340

VIRGINIA

Richmond

9954 Mayland Drive, Suite 6100
Richmond, VA 23233
Risk Control: 1-800-973-9215
Claims: (804) 330-6000

Washington, DC

14200 Park Meadow Dr.
Chantilly, VA 20151
Risk Control: 1-800-973-9215
Claims: 800-368-3562

WASHINGTON

Seattle

1501 4th Avenue, Suite 400
Seattle, WA 98101
Risk Control: 1-800-973-9215

WEST VIRGINIA

Charleston, WV

119 Virginia St. W.
Charleston, WV 25302
Risk Control: 1-800-973-9215
Claims: (443) 353-1000

WISCONSIN

Milwaukee

13935 Bishops Drive, Suite 200
Brookfield, WI 53005
Risk Control: 1-800-973-9215
Claims: 800-842-6172

WYOMING

Denver, CO

6060 S. Willow Drive #300
Greenwood Village, CO 80111
Risk Control: 1-800-973-9215



Report Claims Immediately by Calling*
1-800-832-7839

*Speak directly with a claim professional
24 hours a day, 365 days a year*

*Unless Your Policy Requires **Written** Notice or Reporting

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

A Custom Insurance Policy Prepared for:

**PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043**



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

TYPE AR INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: (6JUB-4N42607-7-21)

RENEWAL OF (6JUB-4N42607-7-20)

**INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA
A STOCK COMPANY**

NCCI CO CODE: 13579

1.

INSURED:

**PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043**

PRODUCER:

**FOSTER AND ASSOCIATES
3100 BRECKINRIDGE BLVD STE 510
DULUTH GA 30096-7507**

Insured is **A LIMITED LIABILITY COMPANY**

Other work places and identification numbers are shown in the schedule(s) attached.

2. The policy period is from **06-15-21** to **06-15-22 12:01 A.M.** at the insured's mailing address.

3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the state(s) listed here:

GA

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each state listed in item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident:	\$	1000000	Each Accident
Bodily Injury by Disease:	\$	1000000	Policy Limit
Bodily Injury by Disease:	\$	1000000	Each Employee

C. OTHER STATES INSURANCE: Part Three of the policy applies to the states, if any, listed here:

**COVERAGE EXCLUDED - REFER TO RESIDUAL MARKET LIMITED OTHER STATES
INSURANCE ENDORSEMENT WC 00 03 26**

D. This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All required information is subject to verification and change by audit to be made **ANNUALLY**.

GEORGIA WORKERS' COMPENSATION ASSIGNED RISK PLAN

DATE OF ISSUE: 06-22-21 WC

ST ASSIGN: GA

OFFICE: RMD GA POOL 775

PRODUCER: FOSTER AND ASSOCIATES

72PXX



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

TYPE AR INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: (6JUB-4N42607-7-21)

CLASSIFICATION SCHEDULE:

CLASSIFICATIONS	CODE NO	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
-----------------	---------	--	---------------------------------------	--------------------------------

SEE EXTENSION OF INFORMATION PAGE - SCHEDULE(S)

SIC-CODE: 1721 NAICS: 238320

	STANDARD
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM \$	1460
PREMIUM DISCOUNT	NONE
0900-10 EXPENSE CONSTANT	160
TERRORISM	NONE
CAT (OTHER THAN CERT ACTS OF TERRORISM)	NONE
TOTAL ESTIMATED PREMIUM	1620
DEPOSIT AMOUNT DUE	1620MP

A/R (WCIP) #

Minimum Premium: \$ 1500

EMPLOYERS LIABILITY MINIMUM: \$ 120

ST ASSIGN: GA

DATE OF ISSUE: 06-22-21 WC

OFFICE: RMD GA POOL 775

PRODUCER: FOSTER AND ASSOCIATES 72PXX



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (A)

POLICY NUMBER: (6JUB-4N42607-7-21)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-GA

INSURED'S NAME: PRIME PAINTERS LLC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 563794723 ENTITY CD 001				
PRIME PAINTERS LLC				
1924 A COLLINS HILL RD				
LAWRENCEVILLE, GA 30043				
SIC CODE: 1721 NAICS: 238320				
PAINTING NOC & SHOP OPERATIONS, DRIVERS	5474	IF ANY	35.76	

1.10% INCREASED LIMITS	\$	NONE
ADD FOR INCREASED LIMITS MINIMUM (9848)		120
.875 MERIT RATING MODIFICATION (9885)		15
ADD FOR POLICY MINIMUM		1355
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1460
EXPENSE CONSTANT(0900)		160
0.0100 TERRORISM (9740)		INCL
0.0100 CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		INCL
TOTAL ESTIMATED PREMIUM		1620
DEPOSIT AMOUNT DUE		1620



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: (6JUB-4N42607-7-21)

LISTING OF ENDORSEMENTS
EXTENSION OF INFO PAGE

We agree that the following listed endorsements form a part of this policy on its effective date.

WC 00 00 01 A - 001	INFORMATION PAGE
WC 00 00 01 A - 001	INFORMATION PAGE 2
WC 00 00 01 A - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 A - 001	ENDORSEMENT LISTING
WC 00 04 24 00 - 001	AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT
WC 00 03 26 A - 001	LIMITED OTHER STATES INSURANCE END
WC 00 04 14 A - 001	NOTIFICATION OF CHG IN OWNR ENDT
WC 00 04 17 B - 001	ASSIGNED RISK LSRP NOTIFICATION END
WC 00 04 22 C - 001	TERRORISM RISK INS PROG REAUTH ACT ENDT
WC 00 04 21 E - 001	CATASTROPHE (O/T CERT ACTS OF TERR) ENDT
WC 00 03 08 00 - 001	PARTNERS, OFFICERS AND OTHERS EXCL ENDT
WC 00 04 19 00 - 001	PREMIUM DUE DATE ENDORSEMENT
WC 10 04 01 00 - 001	GA MERIT RATING ENDT
WC 10 06 01 C - 001	GA CANC NONRENEWAL AND CHANGE ENDT

WC 00 00 00 (C)
(Rev 5-20)

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. Who is Insured

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

D. State

State means any state of the United States of America, and the District of Columbia.

E. Locations

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE

WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

WC 00 00 00 (C)
(Rev 5-20)

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law.

Enforcement may be against us or against you and us.

4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
 - a. benefits payable by this insurance;
 - b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

WC 00 00 00 (C)
(Rev 5-20)

B. We Will Pay

We will pay all sums that you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. For which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. For care and loss of services; and
3. For consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee; provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and
4. Because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. Bodily injury intentionally caused or aggravated by you;
6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or

Canada who is temporarily outside these countries;

7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 U.S.C Sections 901 et seq.), the Nonappropriated Fund Instrumentalities Act (5 U.S.C Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C Sections 1331 et seq.), the Defense Base Act (42 U.S.C Sections 1651–1654), the Federal Mine Safety and Health Act (30 U.S.C Sections 801 et seq. and 901–944), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 U.S.C Sections 51 et seq.), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. Bodily injury to a master or member of the crew of any vessel, and does not cover punitive damages related to your duty or obligation to provide transportation, wages, maintenance, and cure under any applicable maritime law;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We

WC 00 00 00 (C)
(Rev 5-20)

have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. Reasonable expenses incurred at our request, but not loss of earnings;
2. Premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. Litigation costs taxed against you;
4. Interest on a judgment as required by law until we offer the amount due under this insurance; and
5. Expenses we incur.

F. Other Insurance

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. Limits of Liability

Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below:

1. **Bodily Injury by Accident.** The limit shown for "bodily injury by accident – each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.
A disease is not bodily injury by accident unless it results directly from bodily injury by accident.
2. **Bodily Injury by Disease.** The limit shown for "bodily injury by disease – policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of

employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease – each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. Actions Against Us

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page.
3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.

WC 00 00 00 (C)
(Rev 5-20)

4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. Notice

Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

PART FOUR YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE PREMIUM

A. Our Manuals

All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. Classifications

Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by

those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.

WC 00 00 00 (C)
(Rev 5-20)

2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short-rate cancellation table and procedure. Final premium will not be less than the minimum premium.

F. Records

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX CONDITIONS

A. Inspection

We have the right, but are not obliged to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they

comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. Long Term Policy

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. Transfer of Your Rights and Duties

Your rights or duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancellation notice.
4. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

E. Sole Representative

The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancellation.

IN WITNESS WHEREOF, the company has caused this policy to be signed by its President and Secretary at Hartford, Connecticut and countersigned on the Information page by a duly authorized agent of the company.



Secretary



President



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 24 (00)

POLICY NUMBER: (6JUB-4N42607-7-21)

AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

Part Five – Premium, Section G. (Audit) of the Workers Compensation and Employers Liability Insurance Policy is revised by adding the following:

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we may apply an Audit Noncompliance Charge. The method for determining the Audit Noncompliance Charge by state, where applicable, is shown in the Schedule below.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, we will revise your premium in accordance with our manuals and Part 5 – Premium, E. (Final Premium) of this policy.

Failure to cooperate with this policy provision may result in the cancellation of your insurance coverage, as specified under the policy.

Note:

For coverage under state-approved workers compensation assigned risk plans, failure to cooperate with this policy provision may affect your eligibility for coverage.

Schedule

State(s)	Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
NC	ESTIMATED ANNUAL PREMIUM	UP TO THREE TIMES
AL, AR, CT, DE, DC, GA, ID, IL, IA, MN, MS, NE, NM, OR, SC, SD, TN, VT, VA, WV	ESTIMATED ANNUAL PREMIUM	UP TO TWO TIMES
AZ, KS, NJ, WI	ESTIMATED ANNUAL PREMIUM	TWO TIMES
NV	ESTIMATED ANNUAL PREMIUM	UP TO ONE TIMES



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 03 26 (A)**

POLICY NUMBER: (6JUB-4N42607-7-21)

**RESIDUAL MARKET
LIMITED OTHER STATES INSURANCE ENDORSEMENT**

"Part Three—Other States Insurance" of the policy is replaced by the following:

PART THREE OTHER STATES INSURANCE

A. How This Insurance Applies

1. We will pay promptly when due the benefits required of you by the workers compensation law of any state not listed in Item 3.A. of the Information Page if all of the following conditions are met:
 - a. The employee claiming benefits was either hired under a contract of employment made in a state listed in Item 3.A. of the Information Page or was, at the time of injury, principally employed in a state listed in Item 3.A. of the Information Page; and
 - b. The employee claiming benefits is not claiming benefits in a state where, at the time of injury, (i) you have other workers compensation insurance coverage, or (ii) you were, by virtue of the nature of your operations in that state, required by that state's law to have obtained separate workers compensation insurance coverage, or (iii) you are an authorized self-insurer or participant in a self-insured group plan; and
 - c. The duration of the work being performed by the employee claiming benefits in the state for which that employee is claiming benefits is temporary.
2. If we are not permitted to pay the benefits directly to persons entitled to them and all of the above conditions are met, we will reimburse you for the benefits required to be paid.
3. This insurance does not apply to fines or penalties arising out of your failure to comply with the requirements of the workers compensation law.

IMPORTANT NOTICE!

If you hire any employees outside those states listed in Item 3.A. on the Information Page or begin operations in any such state, you should do whatever may be required under that state's law, as this endorsement does not satisfy the requirements of that state's workers compensation law.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 14 (A)

POLICY NUMBER: (6JUB-4N42607-7-21)

**90-DAY REPORTING REQUIREMENT—NOTIFICATION OF CHANGE IN
OWNERSHIP ENDORSEMENT**

You must report any change in ownership to us in writing within 90 days of the date of the change. Change in ownership includes sales, purchases, other transfers, mergers, consolidations, dissolutions, formations of a new entity, and other changes provided for in the applicable experience rating plan. Experience rating is mandatory for all eligible insureds. The experience rating modification factor, if any, applicable to this policy, may change if there is a change in your ownership or in that of one or more of the entities eligible to be combined with you for experience rating purposes.

Failure to report any change in ownership, regardless of whether the change is reported within 90 days of such change, may result in revision of the experience rating modification factor used to determine your premium.

This reporting requirement applies regardless of whether an experience rating modification is currently applicable to this policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium

Insurance Company

Countersigned by _____



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 04 17 (B)**

POLICY NUMBER: (6JUB-4N42607-7-21)

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

**ASSIGNED RISK LOSS SENSITIVE RATING PLAN NOTIFICATION
ENDORSEMENT**

A. LSRP Mandatory Assigned Risk Retrospective Rating Plan

This endorsement is to advise you that, during the term of this policy or upon renewal, you may become subject to the mandatory assigned risk Loss Sensitive Rating Plan (LSRP), which is a retrospective rating plan that may adjust the cost of your workers compensation and employers liability insurance policy. This endorsement must be attached to all assigned risk policies, including policies for professional employer organization (PEO) and temporary arrangements, regardless of LSRP standard premium size in states that have approved the LSRP. In the event that you meet or exceed the eligibility requirements of LSRP, an LSRP contingent deposit equal to 20% of LSRP standard premium is required.

B. Eligibility

1. Your insurance is written under a Workers Compensation Insurance Plan (WCIP) in a state that has approved LSRP.
2.
 - a. LSRP will apply to an individual assigned risk policy if the standard premium meets or exceeds the amount noted in the Schedule, in accordance with NCCI's **Basic Manual**.
 - b. It may not always be possible for a single carrier to provide coverage for all requested states; additional policies issued by more than one carrier may be necessary.
 - c. WCIP policies issued in non-LSRP-approved jurisdictions are not subject to LSRP and are not combinable with WCIP policies in LSRP-approved jurisdictions for eligibility purposes.
 - d. LSRP eligibility may be impacted by ownership or combinability status in accordance with NCCI's **Experience Rating Plan Manual**.
3. LSRP standard premium is defined in accordance with NCCI's **Basic Manual**.

C. Deposit/Initial Premium and LSRP Contingency Deposit

1. Deposit or initial premium is paid on all new and renewal WCIP policies, including LSRP policies, in accordance with NCCI's **Basic Manual**. It is paid to us in addition to the LSRP contingency deposit, which secures all new and renewal LSRP policies as detailed in the LSRP rules.
2. The LSRP contingency deposit paid to us serves as collateral for premium that may be due to us as a result of losses incurred during the policy term.
3. At policy inception, the LSRP contingency deposit is calculated by multiplying the LSRP standard premium by 20%. If WCIP policies are combined for LSRP purposes, the LSRP contingency deposit is calculated by multiplying the combined LSRP standard premium for all policies by 20%.

D. Impact of Changes in LSRP Standard Premium

1. For all policies except for professional employer organizations (PEOs) and temporary arrangements, LSRP may be applied to a policy, or an LSRP policy may be converted to a guaranteed cost policy:



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 04 17 (B)**

POLICY NUMBER: (6JUB-4N42607-7-21)

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

- a. If the LSRP standard premium decreases during the first 120 days, and falls below the LSRP eligibility threshold, your policy will be converted to a guaranteed cost policy, retroactive to policy inception, and your LSRP contingency deposit will be returned.
 - b. If the LSRP standard premium increases during the first 120 days, and meets the LSRP eligibility threshold, LSRP will be applied retroactively to policy inception and the 20% LSRP contingency deposit must be paid to us within 30 days of us issuing notice to you of the application of LSRP.
 - c. If the LSRP standard premium decreases after the first 120 days and falls below the LSRP eligibility threshold, the LSRP continues to be applied to your policy(ies).
 - d. If the LSRP standard premium increases after the first 120 days, and meets the LSRP eligibility threshold, your policy(ies) will remain a guaranteed cost policy(ies) and the LSRP is applied at renewal, subject to meeting the eligibility requirements on the renewal policy(ies).
2. For all PEO and temporary arrangement WCIP policies, if the LSRP standard premium meets or exceeds the eligibility threshold **at any time**, LSRP is applied retroactively to policy inception. The 20% LSRP contingency deposit must be paid to us within 30 days of us issuing notice to you of the application of LSRP.

E. Evasion of LSRP

1. If you take actions for the purpose of avoiding the application of LSRP, or for otherwise legitimate business reasons that nonetheless result in the improper calculation and/or application of LSRP, regardless of intent, any action that results in the miscalculation and/or misapplication of LSRP determined in accordance with the LSRP rules is prohibited. These actions include, but are not limited to:
 - Misrepresentation and/or miscalculation of payroll at application, audit, or renewal
 - Failure to report changes in ownership or ownership information according to the WCIP and NCCI's ***Experience Rating Plan Manual***
 - Violation of any of the terms and conditions under the policy for which this insurance was issued
 - Failure to allow us and/or the Plan Administrator and/or rating organization reasonable access to your facilities or files and records for audit or inspection
 - Failure to disclose to us and/or the Plan Administrator and/or rating organization the full nature and scope of your exposure or business operations
2. In such circumstances, we and/or the Plan Administrator and/or rating organization may obtain any information that indicates evasion or improper calculation or application of LSRP due to actions including, but not limited to, those listed above. We and/or the Plan Administrator and/or rating organization will act to ensure the proper calculation and application of LSRP to inception of all current and preceding WCIP policies impacted by these actions.

This endorsement applies in the states listed in the Schedule below.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 04 17 (B)**

POLICY NUMBER: (6JUB-4N42607-7-21)

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

Schedule

State	Premium Eligibility
ALABAMA	\$250,000
ARIZONA	\$250,000
CONNECTICUT	\$250,000
DISTRICT OF COLUMBIA	\$250,000
GEORGIA	\$250,000
IDAHO	\$250,000
ILLINOIS	\$250,000
INDIANA	\$250,000
KANSAS	\$250,000
NEW HAMPSHIRE	\$250,000
NEVADA	\$250,000
OREGON	\$250,000
SOUTH CAROLINA	\$250,000
SOUTH DAKOTA	\$250,000
TENNESSEE	\$250,000
VERMONT	\$250,000
WEST VIRGINIA	\$250,000



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 22 (C)

POLICY NUMBER: (6JUB-4N42607-7-21)

**TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT
DISCLOSURE ENDORSEMENT**

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2019. It serves to notify you of certain limitations under the Act, and that your insurance carrier is charging premium for losses that may occur in the event of an Act of Terrorism.

Your policy provides coverage for workers compensation losses caused by Acts of Terrorism, including workers compensation benefit obligations dictated by state law. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy, and any applicable federal and/or state laws, rules, or regulations.

Definitions

The definitions provided in this endorsement are based on and have the same meaning as the definitions in the Act. If words or phrases not defined in this endorsement are defined in the Act, the definitions in the Act will apply.

"Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments thereto, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2019

"Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States as meeting all of the following requirements:

- a. The act is an act of terrorism.
- b. The act is violent or dangerous to human life, property, or infrastructure.
- c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
- d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

"Insured Loss" means any loss resulting from an act of terrorism (and, except for Pennsylvania, including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.

"Insurer Deductible" means, for the period beginning on January 1, 2021, and ending on December 31, 2027 an amount equal to 20% of our direct earned premiums during the immediately preceding calendar year.

Limitation of Liability

The Act limits our liability to you under this policy. If aggregate Insured Losses exceed \$100,000,000,000 in a calendar year and if we have met our Insurer Deductible, we are not liable for the payment of any portion of the amount of Insured Losses that exceeds \$100,000,000,000; and for aggregate Insured Losses up to \$100,000,000,000, we will pay only a pro rata share of such Insured Losses as determined by the Secretary of the Treasury.

Form WC 00 04 22 (C)

DATE OF ISSUE: 06-22-21 ST ASSIGN: GA

Page 1 of 2



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 22 (C)

POLICY NUMBER: (6JUB-4N42607-7-21)

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses occurring in any calendar year exceed \$200,000,000, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible .
2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed \$100,000,000 ,000.
3. The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

State	Schedule Rate	Premium
-------	------------------	---------

For all other states please refer to the other Federal Terrorism Risk Insurance Act Disclosure Endorsements attached to your policy

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____

Form WC 00 04 22 (C)

DATE OF ISSUE: 06-22-21 ST ASSIGN: GA
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Page 2 of 2

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 21 (E)

POLICY NUMBER: (6JUB-4N42607-7-21)

**CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)
PREMIUM ENDORSEMENT**

This endorsement is notification that your insurance carrier is charging premium to cover the losses that may occur in the event of a Catastrophe (Other Than Certified Acts of Terrorism) as that term is defined below. Your policy provides coverage for workers compensation losses caused by a Catastrophe (Other Than Certified Acts of Terrorism). This premium charge does not provide funding for Certified Acts of Terrorism contemplated under the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 C), attached to this policy.

For purposes of this endorsement, the following definitions apply:

- Catastrophe (Other Than Certified Acts of Terrorism): Any single event, resulting from an Earthquake, Noncertified Act of Terrorism, or Catastrophic Industrial Accident, which results in aggregate workers compensation losses in excess of \$50 million.
- Earthquake: The shaking and vibration at the surface of the earth resulting from underground movement along a fault plane or from volcanic activity.
- Noncertified Act of Terrorism: An event that is not certified as an Act of Terrorism by the Secretary of the Treasury pursuant to the Terrorism Risk Insurance Act of 2002 (as amended) but that meets all of the following criteria:
 - a. It is an act that is violent or dangerous to human life, property, or infrastructure;
 - b. The act results in damage within the United States, or outside of the United States in the case of the premises of United States missions or air carriers or vessels as those terms are defined in the Terrorism Risk Insurance Act of 2002 (as amended); and
 - c. It is an act that has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
- Catastrophic Industrial Accident: A chemical release, large explosion, or small blast that is localized in nature and affects workers in a small perimeter the size of a building.

The premium charge for the coverage your policy provides for workers compensation losses caused by a Catastrophe (Other Than Certified Acts of Terrorism) is shown in Item 4 of the Information Page or in the Schedule below.

Schedule		
State	Rate	Premium

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective	Policy No.	Endorsement No.
Insured		Premium \$
Insurance Company	Countersigned by	_____
Form WC 00 04 21 (E)		



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 03 08 (OO) – 001**

POLICY NUMBER: (6JUB-4N42607-7-21)

PARTNERS, OFFICERS, AND OTHERS EXCLUSION ENDORSEMENT

The policy does not cover bodily injury to any person described in the Schedule.

The premium basis for the policy does not include the remuneration of such persons.

You will reimburse us for any payment we must make because of bodily injury to such persons.

SCHEDULE

PARTNERS

OFFICERS

OTHERS

SUIUGAN, EMIL



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 04 19 (00)**

POLICY NUMBER: (6JUB-4N42607-7-21)

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

Section D. of Part Five of the policy is replaced by this provision.

PART FIVE

PREMIUM

D. Premium is amended to read:

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. **The due date for audit and retrospective premiums is the date of the billing.**



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC10 04 01 (00)

POLICY NUMBER: (6JUB-4N42607-7-21)

GEORGIA MERIT RATING ENDORSEMENT

This endorsement applies to the insurance provided by this policy because Georgia is shown in Item 3.A. of the Information Page.

The premium for this insurance is subject to the merit rating shown in the Schedule because your premium is less than the amount necessary to be eligible for experience rating. A merit rating adjustment will not be applied if your final premium is calculated to be the Georgia minimum premium for the insured classifications.

SCHEDULE

See Extension of Information Page - Schedule(s)



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 10 06 01 (C)**

POLICY NUMBER: (6JUB-4N42607-7-21)

**GEORGIA CANCELLATION, NONRENEWAL, AND CHANGE
ENDORSEMENT**

This endorsement applies because Georgia is shown in Item 3.A. of the policy Information Page.

Part Six—Conditions, Section D. (Cancellation) of the policy is replaced by the following:

D. Cancellation, Nonrenewal, and Change

1. You may cancel this policy. You must mail or deliver advance notice to us in writing, or deliver advance notice orally or electronically, stating when the cancellation is to take effect. We may require that you provide written, electronic, or other recorded verification of the request before the cancellation takes effect. The cancellation is subject to the following:
 - a. If only your interest is affected, the effective date of cancellation will be the later of the date we receive notice from you or the date specified in the notice.
 - b. If by statute, regulation, or contract this policy may not be cancelled unless notice is given to a governmental agency or other third party, we will mail or deliver at least 10 days' notice to you and the third party as soon as practical after receiving your request for cancellation.Our notice will state the effective date of cancellation, which will be the later of the following:
 - 1) 10 days from the date of mailing or delivering our notice, or
 - 2) The effective date of cancellation stated in your notice to us.
2. We may cancel or nonrenew this policy. We must mail or deliver notice at least 10 days before the effective date of cancellation if this policy has been in effect less than 60 days or if we cancel for nonpayment of premium. If this policy has been in effect 60 or more days and we cancel for a reason other than nonpayment of premium, or if we nonrenew this policy, we must send a notice of cancellation or nonrenewal by certified mail, return receipt requested, to you at your last address of record at least 75 days before the effective date of cancellation or nonrenewal.
3. If we increase current policy premium by more than 15% (other than any increase in premium due to change in risk or exposure, including a change in experience rating modification or resulting from an audit of auditable coverages), we must deliver a notice of our action (including dollar amount of the increase in renewal premium more than 15%) to you, by first class mail, at your last address of record at least 45 days before the expiration date of this policy.
4. If we reduce the policy coverage, we must provide you with written notice at least 45 days before the effective date of the reduction in coverage. The notice will be delivered to you in person or by first class mail to your last address of record. A reduction in coverage made by us includes elimination of coverage, a decrease in scope or less coverage, or the addition of an exclusion. Requests made by you to change, reduce, or eliminate coverage are not considered reductions in coverage.
5. If you fail to submit to, or allow an audit for, the current or most recently expired policy term, we may, after two documented efforts to notify you and your agent of potential cancellation, send via certified mail or statutory overnight delivery, return receipt requested, written notice to you at least 10 days before the effective date of cancellation in lieu of the number of days' notice otherwise required by state law. However, we must not mail a cancellation notice within 20 days of the first documented effort to notify you of potential cancellation.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 10 06 01 (C)**

POLICY NUMBER: (~~6JUB-4N42607~~ - 7 - 21)

6. The policy period will end on the day and hour stated in the cancellation notice except as provided for above.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective
Insured
Insurance Company

Policy No.

Endorsement No.
Premium \$

Countersigned by _____



ATTENTION: CONTRACTORS

YOU MAY BE LIABLE FOR WORKERS COMPENSATION COVERAGE FOR YOUR CONTRACTORS

Did you know that if you have Workers' Compensation Insurance and you use contractors in your business you may be liable for uninsured contractors? Without valid Workers' Compensation certificates of insurance for your contractors you may be charged an additional premium.

Your contractors may provide you with a certificate of insurance as evidence of Workers' Compensation coverage. The certificate of insurance lists the Workers' Compensation carrier, policy number and policy term. The contractor working for you is shown as the "Insured", and your company as "Certificate Holder". However, a certificate of insurance does not guarantee that coverage is valid and in force when the contractor is working for you.

Why do you need to know if a Certificate of Insurance is valid?

- You need to know this because if one of your contractor's policies cancels you may be charged an additional premium during the period contractor was uninsured.
- As the primary contractor you may not always be notified of a contractor's policy cancellation, which would then make you liable for providing Workers Compensation insurance for these uninsured contractors and premiums will be assessed to you.
- Just because you are a certificate holder does not guarantee that workers compensation coverage is valid for the contractor or that you will be notified of cancellation.

You now have the ability to verify and track contractor's coverage:

Most State Board of Workers' Compensation websites have a link to verify Workers' Compensation coverage. Please take a few minutes to review the following tips and procedures to help you to verify if all of your contractors have Workers' Compensation coverage.

Go to: <https://www.ewccv.com/cvs>

- After accepting the website terms, you can select your state, date of payment and identify your subcontractor for verification.
- In addition to verifying workers compensation coverage for your subcontractor(s), you can also subscribe to track your subcontractor's policy to be notified if their policy cancels or is reinstated at any time. Please visit www.travelers.com/audit for additional information on tracking your subcontractor's workers compensation policies.
- If you find coverage was cancelled or not in effect, please follow up with your contractor immediately as you may be liable for the uninsured exposure. **Remember, you as the primary contractor are liable for providing workers compensation insurance for uninsured subcontractors.**

-----Important Reminder to Producers on CERTIFICATES OF INSURANCE

As stated on the NCCI Binder letter and outlined in the NCCI Assigned Risk Supplement to the Basic Manual, the producer is required to provide the assigned Carrier a copy of each Certificate of Insurance issued by the producer on behalf of the insured.

Producers are authorized to issue certificates of workers compensation insurance when all of the following conditions exist:

- The certificate is issued only on the standard ACORD form
- The certificate is issued only for operations listed in 3.A. of the Information Page
- The policy terms are unchanged
- The certificate holder is not extended any greater rights than the insured
- The assigned carrier is provided with a copy of each certificate issued



ATENCIÓN: CONTRATISTAS USTED PUEDE SER RESPONSABLE POR EL SEGURO DE TRABAJO DE SUS CONTRATISTAS

¿Sabía usted que si tiene un Seguro de Compensación de Trabajadores (Worker's Compensation Insurance) y si utiliza contratistas en su empresa usted puede ser sujeto a que los contratistas no tengan seguro? Si usted **NO** tiene un Certificado de Seguro de Compensación de Trabajadores válido para sus contratistas es posible que usted sea responsable de pagar una prima adicional en su póliza.

Los contratistas pueden proporcionarle un certificado de seguro como evidencia de que tienen Seguro de Compensación de Trabajadores (Worker's Compensation Insurance). El certificado de seguro le proveerá el nombre de la compañía de seguro de trabajadores (Insurance Carrier), el número de póliza (policy number) y el período de tiempo (policy period) por el cual contratistas estuvo asegurado. El contratista que trabaje para usted se muestra como el "Asegurado" (Insured) y su negocio como "Titular del Certificado" (Certificate Holder). Sin embargo, tenga presente que un certificado de seguro **NO** le garantiza que la cobertura sea válida y activa cuando un contratista esté trabajando para usted.

¿Por qué necesita usted saber si un certificado de seguro es válido?

- Si una de las pólizas de sus contratistas se cancela una prima adicional puede ser cobrada por el período de tiempo que el contratista no fue asegurado y que trabajo para usted.
- Es posible que usted **NO** siempre sea notificado de la cancelación de la póliza de uno de sus contratistas(s) por lo cual usted sería el responsable de proporcionar seguro de compensación para estos contratistas no asegurados y además, usted puede ser responsable de pagar una prima adicional en su póliza.
- Sólo porque usted es el titular de un certificado no garantizan que la cobertura de compensación de los trabajadores sea válida para el contratista o que recibirá una notificación de cancelación.

Ahora tiene la capacidad de verificar y seguir la cobertura del contratista:

La mayoría de los Estados tiene una página de internet dedicada a los empleadores, donde se puede verificar la cobertura de seguros de contratistas. Tome unos minutos para revisar los siguientes consejos y procedimientos que le ayudarán a verificar si todos los contratistas que trabajan para usted tienen cobertura de compensación de trabajadores.

***VISITE:** <https://www.ewccv.com/cvs>

- Después de aceptar los términos del sitio web, puede verificar seleccionando su estado, fecha de pago e identificar a su subcontratista.
- Además de verificar la cobertura de compensación para trabajadores de su(s) subcontratista(s), también puede suscribirse para seguir la póliza de su subcontratista y recibir una notificación si la póliza se cancela o se restablece en cualquier momento. Visite www.travelers.com/audit para obtener información adicional sobre el seguimiento de la póliza de trabajadores de su subcontratista.
- Si encuentra que la cobertura se canceló o no está activa, comuníquese con su contratista inmediatamente porque usted puede ser responsable de la exposición de su(s) subcontratista(s). **Recuerde, usted, como contratista principal, es responsable de proporcionar un seguro de compensación para trabajadores de subcontratistas sin seguro.**



**ATENCIÓN: CONTRATISTAS
USTED PUEDE SER RESPONSABLE POR EL SEGURO DE TRABAJO
DE SUS CONTRATISTAS**

-----Recordatorio importante para los Agentes sobre CERTIFICADOS DE SEGUROS-----

Como se indica en la carta de NCCI Binder y se describe en el Suplemento de Riesgo Asignado de NCCI del Manual Básico, el agente debe proporcionar a la empresa asignada una copia de cada Certificado de Seguro emitido por el agente en nombre del asegurado.

Los Agentes de Seguros están autorizados a emitir certificados de seguro de compensación para trabajadores cuando existen todas las siguientes condiciones:

- El certificado se emite solo en el formulario ACORD estándar
- El certificado se emite solo para las operaciones enumeradas en 3.a. de la página de información
- El periodo de la póliza no es cambiado
- El titular del certificado no tiene más derechos que el asegurado.
- La empresa asignada recibe una copia de cada certificado emitido.

IMPORTANT NOTICE – NEW, UNCOLLECTED OR UNCONTEMPLATED SURCHARGES

NO COVERAGE IS PROVIDED BY THIS NOTICE. THIS NOTICE DOES NOT AMEND ANY PROVISION OF YOUR POLICY. YOU SHOULD REVIEW YOUR ENTIRE POLICY CAREFULLY FOR COMPLETE INFORMATION ON THE COVERAGES PROVIDED AND TO DETERMINE YOUR RIGHTS AND DUTIES UNDER YOUR POLICY. PLEASE CONTACT YOUR AGENT OR BROKER IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR ITS CONTENTS. IF THERE IS ANY CONFLICT BETWEEN YOUR POLICY AND THIS NOTICE, THE PROVISIONS OF YOUR POLICY PREVAIL.

The insurer is responsible for the collection of any surcharge related to the policy premium in accordance with state laws or regulations. While surcharges are commonly known at the time of policy issuance, there are instances when a state amends existing, or institutes new, surcharge rates after policy issuance. The insured is responsible to reimburse the insurer when billed for the amount of any surcharge.



PRIVACY NOTICE

THE TRAVELERS INSURANCE COMPANIES

PRIVACY POLICY

Thank you for selecting **THE TRAVELERS INSURANCE COMPANIES** as your workers compensation insurer. At **THE TRAVELERS INSURANCE COMPANIES** a subsidiary of Travelers, we recognize that privacy is important to you. That is why we are committed to protecting your privacy through the adoption of the following privacy principles:

Collection Of Information

We collect, retain, and use information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, only where we believe that it will help or is necessary to provide you products and services or otherwise conduct our business. We collect nonpublic personal financial information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, from the following sources:

- information we receive from you or through your agent or broker on applications or other forms;
- information we receive from or about you in the process of adjusting claims;
- information about your other transactions, including risk control and other consulting services, with us, our affiliates or other third parties;
- information about your coverages and loss activity with other carriers; and
- information we receive from a consumer reporting agency.

Such information includes identifying information such as policyholder, participant, beneficiary or claimant name, address, and social security number; financial information such as income, payment history, or credit history; and, under certain circumstances, health information such as information about an illness, disability, or injury. It could also include information on claims with other insurance companies and us and the condition and maintenance of your property.

Disclosure Of Information

We usually do not disclose nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, without your consent. However, in some circumstances we may disclose information to others without your prior authorization. The most common disclosures are to the following persons:

- our affiliated property and casualty insurance companies;
- state insurance departments, for their regulation of our business;
- other government authorities;
- our agents and brokers as necessary to conduct our business;
- organizations that perform underwriting and claims investigations;
- another insurance company to which you have applied for a policy or submitted a claim;
- insurance support agencies, law enforcement agencies and our reinsurers; and
- any other third party, as permitted or required by law.

<p>Most importantly, THE TRAVELERS INSURANCE COMPANIES does not and will not disclose or sell nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to anyone for marketing purposes.</p>

Confidentiality And Security

We restrict access to nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to those who need it to serve your insurance needs and to maintain and improve customer service. We maintain physical, electronic, and procedural safeguards that comply with federal and state laws and regulations to guard your nonpublic personal information.

Disclosure and Protection of Former Customers' Information

We may disclose all the personal information we have collected, as described above. However, even if you no longer have a customer relationship with us, we will continue to follow our privacy policies and practices to protect your information.

Changes In Privacy Policy

We may choose to modify our policy regarding the treatment of personal information at any time. Before we do so, we will notify you and provide an updated privacy notice.

IMPORTANT NOTICE – INDEPENDENT AGENT AND BROKER COMPENSATION

NO COVERAGE IS PROVIDED BY THIS NOTICE. THIS NOTICE DOES NOT AMEND ANY PROVISION OF YOUR POLICY. YOU SHOULD REVIEW YOUR ENTIRE POLICY CAREFULLY FOR COMPLETE INFORMATION ON THE COVERAGES PROVIDED AND TO DETERMINE YOUR RIGHTS AND DUTIES UNDER YOUR POLICY. PLEASE CONTACT YOUR AGENT OR BROKER IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR ITS CONTENTS. IF THERE IS ANY CONFLICT BETWEEN YOUR POLICY AND THIS NOTICE, THE PROVISIONS OF YOUR POLICY PREVAIL.

For information about how Travelers compensates independent agents and brokers, please visit www.travelers.com, call our toll-free telephone number 1-866-904-8348, or request a written copy from Marketing at One Tower Square, 2GSA, Hartford, CT 06183.

ATTENTION

The enclosed Posting Notices must be displayed in a prominent location in the workplace. It is your responsibility to distribute the applicable Posting Notice(s) to each of your locations and to notify each location that it must post these notices, and keep them posted, in a conspicuous location frequented by your employees.

Posting Notices for the states of Missouri, New Mexico and Texas (Spanish Version) are provided on two separate forms, which must be connected to create one large notice to be posted.

Please contact us at wcppn@travelers.com for assistance in completing the healthcare provider information on Posting Notices for Georgia, Pennsylvania, Tennessee and Virginia.

While carriers are required to provide Posting Notices in AZ, AR, CA, DC, FL, ID, KS, KY, MO, and NY, Travelers is providing Posting Notices to you for all states* covered under your policy as a courtesy. All such Posting Notices remain subject to state regulation and are subject to change at any time. For states in which Travelers is providing you with Posting Notices as a courtesy, Travelers assumes no obligation to provide you with revised notice(s) if a state changes its Posting Notice during the current policy term.

If you need additional copies of any Posting Notice, please contact your agent.

* Excluding: DE, GU, IA, NE, ND, OH, PR, SD, VI, WA, WI and WY. The following states do not require posting notices: DE, GU, IA, NE, SD, and WI. The state of OR will provide the posting notice directly. The following are monopolistic states – there are no posting notices for employers' liability: ND, OH, PR, VI, WA and WY.

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including, an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation

270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682

<http://www.sbwc.georgia.gov>

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

(Additional doctors may be added on a separate sheet)

The insurance company providing coverage for this business
under the Workers' Compensation Law is:

THE TRAVELERS INSURANCE COMPANIES

Name

P.O. BOX 4614
BUFFALO, NY 14240-4614

1-800-238-6225

address

phone

**IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818
OR 1-800-533-0682 OR VISIT <http://www.sbwc.georgia.gov>**

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to
penalties of up to \$10,000.00 per violation (O.C.G. A. § 34-9-18 and § 34-9-19)

WC-P1 (7/2006)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION**BILL OF RIGHTS FOR THE INJURED WORKER**

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than \$675 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than \$675 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than \$450 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than \$450 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to \$7,500 and two-thirds of your average weekly wage, but not more than \$675 per week. A widowed spouse with no children will be paid a maximum of \$270,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: <http://www.sbwcc.georgia.gov>. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-237-2629.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than \$10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA**DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO**

Según lo requiere la Ley O.C.G.A. § 34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están des critos abajo.

Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo. Todas las lesions que ocurren en o antes 30 de junio de 2013 se tendrá derecho a beneficios médicos de por vida. Si el accidente ocurrió en o 1 de julio del 2013 el tratamiento médico será limitado a un máximo de 400 semanas a partir de la fecha del accidente. Si su lesión es catastrófica en la naturaleza que puede tener derecho a beneficios médicos de por vida.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$675 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-0849.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no mas de \$675 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de \$450 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de \$450 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$675 por semana. Una esposa viuda sin niños se le pagara un máximo de \$270,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador ser n negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: <http://www.sbwcc.georgia.gov>. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-237-2629.

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 O 1-800-533-0682 O VISITA SITIO WEB: <http://www.sbwcc.georgia.gov>
CUALQUIER DECLARACIÓN FALSA Y DELIBERADA PARA OBTENER O NEGAR BENEFICIOS ES UNA OFENSA CRIMINAL Y ES SUJETO A PENALIDADES DE HASTA \$10,000 POR CADA VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19).

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISAR AL EMPLEADOR PERSONALMENTE, UN AGENTE, PREPRESENTANTE, PATRON, SUPERVISOR O CAPATAZ.

Si un trabajador es lesionado en el trabajo el empleador debe pagar gastos médicos y rehabilitación dentro de los límites de la ley. En algunos casos el empleador también pagara una parte de los salarios perdidos de los empleados.

Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de la Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de la lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clínicas industriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un médico minoritario, cuando sea posible (vea la regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un cambio de un doctor a otro en la lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de la Junta Estatal de Compensación de Trabajadores.

Junta Estatal de Compensación de Trabajadores

270 Peachtree Street, N.W.

Atlanta, Georgia 30303-1299

404-656-3818

o 1-800-533-0682

<http://www.sbwc.georgia.gov>

nombre /dirección /teléfono

nombre /dirección /teléfono

nombre /dirección /teléfono

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nombre /dirección /teléfono

nombre /dirección /teléfono

(Médicos adicionales pueden ser agregados en una hoja separada.)
La compañía de seguro que provee cobertura para esta Empresa bajo la
ley de Compensación de Trabajadores es:

THE TRAVELERS INSURANCE COMPANIES

Nombre

P.O. BOX 4614

BUFFALO, NY 14240-4614

1-800-238-6225

dirección

teléfono

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: <http://www.sbwc.georgia.gov>

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER O NEGAR BENEFICIOS ES UN
CRIMEN SUJETO A PENALIDADES DE HASTA 10,000.00 POR VIOLACIÓN (O.C.G.A. §34-9-18 §34-9-19.)

WC-P1 (7/2006)

STATE WCIP COMMISSION SCALES

The Residual Market Workers Compensation Insurance Plans (WCIP) allow licensed producers to receive a producer fee for services provided to the employer. The producer fee is calculated using a graduated producer fee schedule that is filed by the Plan Administrator with the state regulatory authorities. The payment of producer fees varies by state. Producer fees are typically based on the state standard premium charged and collected or total premium charged and collected.

<u>State</u>	<u>Residual Market Commission Scale</u>			
Alabama	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%	Over \$100,000 @ 2%
Alaska *	Flat 5%			
Arizona	Flat 5%			
Arkansas	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Connecticut	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Delaware	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
District of Columbia	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Florida (FWCJUA)	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Georgia *	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Idaho	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Illinois *	First \$1,000 @ 8%,	Next \$4,000 @ 4%,	Next \$95,000 @ 2%,	Over \$100,000 @ 1%
Indiana	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Iowa	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Kansas	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Massachusetts	First \$1,000 @ 9%,	Next \$4,000 @ 5%,	Next \$95,000 @ 4%,	Over \$100,000 @ 3%
Michigan	First \$5,000 @ 5%,	Next \$95,000 @ 4%,	Next \$ 400,000 @ 3%,	Over \$500,000 @ 2%
Missouri	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Nebraska	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Nevada	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
New Hampshire	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
New Jersey	First \$1,000 @ 8%,	Next \$4,000 @ 6%,	Next \$95,000 @ 4%,	Over \$100,000 @ 2%
North Carolina *	Flat 5%			
Oregon	First \$1,000 @ 5%,	Next \$4,000 @ 3%,	Next \$95,000 @ 2%,	Over \$100,000 @ 1%
South Carolina	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
South Dakota	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Tennessee *	First \$1,000 @ 8%,	Next \$4,000 @ 6%,	Next \$95,000 @ 5%,	Over \$100,000 @ 3%
Vermont	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Virginia	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
West Virginia	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Wisconsin *	First \$10,000 @ 4%, Over \$10,000 @ 1%			

* *Total Premium Charged and Collected*

NOTE: All commissions are calculated and paid based on state standard premium except where indicated. State Standard Premium generally excludes the impact of Premium Discount, Expense Constant, Terrorism, Catastrophe (other than certified acts of terrorism), and taxes and assessments in the calculation.

Total Premium Charged and Collected generally includes the impact of Premium Discount, Expense Constant, Terrorism, and Catastrophe (other than certified acts of terrorism) in the calculation.

Refer to the individual state Workers' Compensation Insurance Plan and the state's algorithm for exact definitions.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

CHANGE DOCUMENT WC 99 99 98 (A)

POLICY NUMBER: (6JUB-4N42607-7-21)

CHANGE EFFECTIVE DATE: 06-15-21

NCCI CO CODE: 13579

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: PRIME PAINTERS LLC

This change is issued by the Company or Companies that issued the policy and forms a part of the policy. It is agreed that the policy is amended as follows:

An absence of an entry in the premium spaces below means that the premium adjustment, if any, will be made at time of audit.

ADDITIONAL PREMIUM \$ 151577
ADDITIONAL NON-PREMIUM \$ NIL

RETURN PREMIUM \$ NIL
RETURN NON-PREMIUM \$ NIL

**THE CURRENT POLICY EXPOSURES AND/OR CLASSIFICATIONS HAVE BEEN
UPDATED TO REFLECT THE LATEST AVAILABLE AUDIT INFORMATION.**

THE FOLLOWING ENDORSEMENTS ARE ADDED:

WC89041500 POLICY INFO PAGE ENDT
WC89060100 CHANGE POLICY INFO ENDT - NAME
WC89060800 CHANGE POLICY INFO ENDT - LOCATION ADDR
WC89061400 POLICY INFORMATION PAGE ENDORSEMENT
WC999998 A CHANGE DOCUMENT

DATE OF ISSUE: 08-16-21
POL. EFF. DATE: 06-15-21

WC CHANGE NO: 001
POL. EXP. DATE: 06-15-22

PAGE 001 OF LAST

OFFICE: RMD GA POOL
PRODUCER:

775

72PXX

COUNTERSIGNED AGENT



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (A)

POLICY NUMBER: (6JUB-4N42607-7-21)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-GA

INSURED'S NAME: PRIME PAINTERS LLC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 563794723 ENTITY CD 001				
PRIME PAINTERS LLC				
1924 A COLLINS HILL RD				
LAWRENCEVILLE, GA 30043				
SIC CODE: 1721 NAICS: 238320				
PAINTING NOC & SHOP OPERATIONS, DRIVERS	5474	423069	35.76	151289

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$	1664
.875 MERIT RATING MODIFICATION		NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		152953
EXPENSE CONSTANT(0900)		160
0.0100 TERRORISM (9740)		42
0.0100 CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		42
TOTAL ESTIMATED PREMIUM		153197
DEPOSIT AMOUNT DUE		153197



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 89 04 15 (00) – 001

POLICY NUMBER: (6JUB-4N42607-7-21)

**POLICY INFORMATION PAGE
ENDORSEMENT**

Item #4 is changed to the following:

PREMIUM BASIS				
Classifications	Code No.	Total Estimated Annual Remuneration	Rate Per \$100 of Remuneration	Estimated Annual Premium

SEE CHANGE DOCUMENT OR INFORMATION PAGE SCHEDULE

Total Estimated Annual Premium \$

Minimum Premium \$

Deposit Premium \$

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED.

DATE OF ISSUE: 08-16-21

ST ASSIGN: GA



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 89 06 01 (00) - 001

POLICY NUMBER: (6JUB-4N42607-7-21)

**POLICY INFORMATION PAGE
ENDORSEMENT**

The Insured's Name is changed to read: **PRIME PAINTERS LLC**

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 89 06 08 (00) – 001

POLICY NUMBER: (6JUB-4N42607-7-21)

**POLICY INFORMATION PAGE
ENDORSEMENT**

The Location of Insured is changed to read:

SEE CHANGE DOCUMENT OR INFORMATION PAGE SCHEDULE

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 89 06 14 (00) – 001

POLICY NUMBER: (6JUB-4N42607-7-21)

**POLICY INFORMATION PAGE
ENDORSEMENT**

Item 3.D. Endorsement numbers is changed to read:

SEE CHANGE DOCUMENT OR INFORMATION PAGE SCHEDULE

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED.

DATE OF ISSUE: 08-16-21

ST ASSIGN: GA

TRAVELERSTRAVELERS - RMD
P.O. BOX 5600

HARTFORD CT 06102-5600

Account Bill

Account No. 2929E3213

Date of This Bill 08/25/21

TOTAL BALANCE

\$311,367.00

MINIMUM DUE

\$311,367.00

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043

PAYMENT MUST BE RECEIVED BY:

SEPTEMBER 14, 2021**ACCOUNT BILLING SUMMARY**

POLICY	TYPE	POLICY PERIOD	MIN. DUE	BALANCE
4N426077 UB	Workers Comp	06/15/21 To 06/15/22	\$151,577.00	\$151,577.00
4N426077 UB	Workers Comp	06/15/20 To 06/15/21	159,790.00	159,790.00**
TOTAL BALANCE			\$311,367.00	\$311,367.00

TRANSACTIONS SINCE LAST STATEMENT

Total Transactions (See Transaction Detail Section)	+311,367.00
TOTAL BALANCE	\$311,367.00

TRANSACTION DETAIL

POLICY NUMBER 4N426077 UB	Workers Comp	
06/15/20	Final Audit	159,790.00
06/15/21	Change	151,577.00
TOTAL TRANSACTIONS		\$311,367.00

CONTINUED ON NEXT PAGE

TO ENSURE PAYMENT IS PROPERLY APPLIED, detach the return payment stub and mail to the return address below.

ASSIGNED RISK WORKERS COMPENSATION INSURANCE

PAY ONLINE AT TRAVELERS.COM/EXPRESSPAY

648842H 2021237 0067 775 072PXX

Payment Coupon Make checks payable to: TravelersFOSTER AND ASSOCIATES
PRIME PAINTERS LLC

2929E3213

Travelers
Dept. 98699
PO Box 660333
Dallas, TX 75266-0333

Include Account Number on the check.

Change of Address?
Place an "X" here.
Print changes on reverse side.PAYMENT MUST BE RECEIVED BY
SEPTEMBER 14, 2021

TOTAL BALANCE	\$311,367.00
MINIMUM DUE	\$311,367.00
AMOUNT ENCLOSED	



9334143432363037372021082520210914031136700000000000000009869900000220077

Customer Service Contacts

Billing Questions MONDAY-FRIDAY, 7:00 A.M. - 8:00 P.M. EST 800-443-4404

Your Account Number: 2929E3213

Automated Inquiry: 24 hrs a day, 7days a week 800-443-4404

Direct Inquiries To: TRAVELERS
 P.O.Box 5600
 Hartford CT 06102-5600
 (800) 443-4404

<u>Policy Information</u>		<u>Insuring Company</u>
4N426077	2021	TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA
4N426077	2020	TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

SPECIAL MESSAGES

Consider making your next payment online at www.travelers.com/ExpressPay
Log on using your account number and zip code to make a bank account payment today.

ExpressPay - Fast. Secure. Easy.

The policy number shown above consists of your billing policy number and policy form.
For the complete policy number refer to your policy paper.

This bill is rendered by THE TRAVELERS INDEMNITY COMPANY affiliated
company indicated on the policy shown on this notice.

Your payment must be received by the "Due Date". Failure to pay the amount due may
affect your insurability under the state Workers Compensation Insurance Plan.

You must pay at least the minimum due or up to the total balance due. If at any time you
pay us more than the minimum due, and it covers your future installments you will not
receive a bill.

If you dispute any of the amount due on this bill, you must do the following by the due
date in order to avoid cancellation procedures from being initiated.

- 1) Provide to us written documentation outlining and explaining the specific areas of
dispute as well as your estimate of the undisputed amount due and your method of
calculation. You must pay the undisputed amount by the "due date".
- 2) Make a written request to the plan administrator for a hearing on the dispute. You
may contact us in writing for the name of the plan administrator in your state.

All written correspondence should be mailed to the address found in the Customer Service
Contacts section of this invoice.

To order Loss Control Services, please call the 1-800 number found in the Customer Service
Contacts section of this invoice.

If you are paying with a check from a Personal Checking Account, you authorize us to
either use information from your check to make a one-time electronic funds transfer from
your account or to process the payment as a check. If you are paying with a check from a
Business Checking account, we will process the payment as a check.

Notice of Cancellation

Account 2929E3213

Page 1 of 4

775

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043

**YOUR INSURANCE POLICY IS SUBJECT TO CANCELLATION. PLEASE
SEE REVERSE SIDE FOR NOTICE OF CANCELLATION.**

TRAVELERS**NOTICE OF CANCELLATION
FOR NON-PAYMENT OF PREMIUM**

Insuring Company: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Workers Comp

POLICY NO. 4N426077 UB**Issue Date** 09/16/21**ACCOUNT** 2929E3213

Page 2 of 4

**Named Insured
and Mailing Address** PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE GA 30043

DIRECT INQUIRIES TO:

TRAVELERS

P.O. Box 5600

Hartford

(800) 443-4404

CT 06102-5600

EFFECTIVE DATE OF CANCELLATION: OCTOBER 06, 2021 at 12:01 am

THIS POLICY IS CANCELLED EFFECTIVE AT THE DATE AND TIME INDICATED IN THIS NOTICE.
THIS IS THE FINAL NOTICE OF CANCELLATION WE WILL SEND PRIOR TO THE EFFECTIVE DATE AND
TIME OF CANCELLATION INDICATED IN THIS NOTICE.

Premium Information**POLICY NUMBER** 4N426077 UB**POLICY PERIOD** 06/15/21 To 06/15/22**Previous balance** \$311,367.00**Pay****MINIMUM DUE** \$311,367.00**Either****Amount****TOTAL DUE** \$311,367.00**DUE****OCTOBER 06, 2021 at 12:01 am**

Consider making your next payment online at www.travelers.com/ExpressPay
Log on using your account number and zip code to make a bank account payment today.

ExpressPay - Fast. Secure. Easy.

The policy number shown above consists of your billing policy number and policy form.
For the complete policy number refer to your policy paper.

This bill is rendered by THE TRAVELERS INDEMNITY COMPANY
company indicated on the policy shown on this notice.

affiliated

TO ENSURE PAYMENT IS PROPERLY APPLIED, detach the return payment stub and mail to the return address below.
ASSIGNED RISK WORKERS COMPENSATION INSURANCE **PAY ONLINE AT TRAVELERS.COM/EXPRESSPAY**

648844W 2021259 0082 775 072PXX

Payment Coupon Make checks payable to: Travelers

FOSTER AND ASSOCIATES
PRIME PAINTERS LLC

2929E3213 **4N426077 UB**

Travelers
Dept. 98699
PO Box 660333
Dallas, TX 75266-0333



Include Account Number on the check.



Change of Address?
Place an "X" here.
Print changes on reverse side.

PAYMENT MUST BE RECEIVED BY
OCTOBER 06, 2021

TOTAL BALANCE
\$311,367.00
MINIMUM DUE
\$311,367.00
AMOUNT ENCLOSED

933414343236303737202109162021100603113670000000000000009869900000220000



Notice of Cancellation

Account 2929E3213

Page 3 of 4

Your policy designated herein is cancelled in accordance with its terms as of the effective date of cancellation at 12:01 am. Any premium adjustment required by the policy will be made.

A notice of cancellation for your policy has been filed with the state insurance department and the Plan Administrator because of your failure to remit the Past Due Amount. Failure to satisfy this outstanding premium obligation may affect your insurability under the state Workers Compensation Insurance Plan and may result in your account being referred to a collection agency.

If you dispute any amount due on this Direct Notice of Cancellation, you must do all of the following by the "due date" in order to prevent cancellation.

- 1) Provide to us written documentation outlining and explaining the specific areas of dispute as well as your estimate of the undisputed amount due and your method of calculation. You must pay the undisputed amount by the "due date".
- 2) Make a written request to the plan administrator for a hearing on the dispute. You may contact us in writing for the name of the plan administrator in your state.

All written correspondence should be mailed to the address found in the Customer Service Contacts section of this invoice.

You have a right to make a written request to us for more explicit detail on the reason your policy has been terminated. If you elect to write to us please address your correspondence to the company at the address shown on this notice. We will answer your written request within 6 days of our receipt.

If you are paying with a check from a Personal Checking Account, you authorize us to either use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check. If you are paying with a check from a Business Checking account, we will process the payment as a check.



Notice of Cancellation

Account 2929E3213

Page 4 of 4

***** QUESTIONS? *****

If you have any questions about this statement, please contact Billing Customer Service or the On-line Telephone Inquiry Service. To reach Billing Customer Service or the Telephone Inquiry dial the phone number provided in the Customer Service Contact Section of this bill.

Your 9 character billing account number is: --- 2929E3213.

**CANCELLATION CHANGE SLIP-
COMMERCIAL**

DO NOT ATTACH TO POLICY

INSURING COMPANY:
TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

PRODUCER TO NOTE: The return premium indicated below may include installments not yet due. Check your records before making a refund to the insured. If Assigned Risk policy, the servicing carrier will issue return premium if applicable.

POLICY NUMBER (6JUB-4N42607-7-21)			OFFICE/CODE/DISTRICT RMD GA POOL /775 /		DATE/WRITER 10-07-21 WC	
NAMED INSURED PRIME PAINTERS LLC			PRODUCER & CODE FOSTER AND ASSOCIATES 72PXX			
			PREMIUM FINANCED BY:			
EFF.DATE CANG. 10-06-21	POLICY EFF. 06-15-21	POLICY EXPIR. 06-15-22	REINSURANCE	MODE OF ADJUSTMENT A	MODE OF CANCELLATION PRO RATA	

REASON FOR CANCELLATION

CANCEL NOTICE - COMPANY REQUEST NONPAYMENT OF PREMIUM

A/C MONTH	RET. PREM.	COMM.	ITEM

A/C MONTH	RET. PREM.	COMM.	ITEM

TOTAL EAR. PREM.
SUBJECT TO AUDIT
TOTAL RET. PREM.
SUBJECT TO AUDIT

This document is issued only by the Company or Companies which issued this policy.



www.travelers.com/audit
Returning User ID: 2929e3213

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE, GA 30043

Premium Audit Online Invitation
Due Date: 11/26/2021
Date Created: 10/28/2021
Policy Period: 06/15/2021 to 10/06/2021
Policy Number: UB - 4N426077

Schedule Your Audit 1-800-842-4271 Ext: 7
How may we help? 1-800-842-4271 or audits@travelers.com

Dear Customer,

At the end of your policy period Travelers conducts a premium audit to reconcile what was estimated at the beginning of your policy(ies) to what actually occurred. To do this, we ask you to provide information to ensure that your premium reflects your business operations and any changes that may have occurred during the policy period. It's an industry-standard practice and your participation in providing this information is essential in order to calculate your final premium.

Scheduling Your Audit

Our aim is to arrange a date and time that best accommodates your schedule and your auditor's availability. A Premium Audit representative will be contacting you in the coming weeks to set a date for your audit and confirm the appointment details. To change the location of your audit from what is shown below, you can register or login to the Premium Audit site or call the Appointment Scheduling number at the top of the page.

EMIL SUIUGAN
1760 SHADY CREEK LN
LAWRENCEVILLE, GA 30043
1-770-717-7380
PRIMEPAINTERSLLC1@ICLOUD.COM

Get a Head Start – Schedule Your Appointment and Submit Your Documents Online

Use the information at the top of this page to register and/or login to the Premium Audit customer site to take advantage of the following features:

- **NEW** - Schedule your appointment
- Confirm your appointment details (after scheduled)
- View your auditor's contact information
- Securely submit documents in advance of your appointment to streamline your audit and potentially minimize onsite time*
- Check the status of your audit
- Access prior audits (when applicable) and review your Premium Audit Adjustment Explanation.

*Uploading your documents can expedite the audit appointment; however the auditor must still meet with you or your representative in person.

How to Prepare for Your Premium Audit

We acknowledge that it takes time to gather the information necessary for your audit and we have heard from customers that organizing the correct documents ahead of time helps the audit go smoothly. Here are some resources to help with your audit preparation:

- Contact an Appointment Coordinator to schedule your audit and confirm the meeting location
- Register and/or login using the information above to submit your audit documents prior to your appointment*
- Reach out to Customer Service to answer questions you may have about your audit

Getting Started

If you need to logon as a new user you can do that by going to www.travelers.com/register/biz.

What You Will Need

Please have the information listed below uploaded to the portal or available for your audit appointment. Visit travelers.com/audit for Frequently Asked Questions, Recordkeeping Tips and Required Document Checklists (note: this may be a different site from where you are directed to register).

- **Payroll Information.** Include information for each owner, officer and employee during the policy term.
- **Payroll Verification.** Federal Form 941 and/ or State Unemployment Wage Reports (SUTA). If you have employees in California, DE-9 forms are required.
NOTE: If the documents above do not apply to your business, review the detail in the website for alternate documents applicable to your business type.
- **Contractor Information.** Include information for any contract laborer/ subcontractor for the policy term (if applicable).
- **Certificate of Insurance.** Provide certificates of insurance for insured subcontractors paid during the period.

Your information is strictly confidential and will be used only for the purpose of completing your audit.

Thank you. We appreciate your time and assistance to complete your premium audit.

Sincerely,

The Travelers Premium Audit Team



www.travelers.com/audit
Returning User ID: 2929e3213

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE, GA 30043

Notice of Noncompliance

Date Created: 11/16/2021
Policy Period: 06/15/2021 to 10/06/2021
Policy Number: UB - 4N426077

Schedule Your Audit 1-800-842-4271 Ext: 7
How may we help? 1-800-842-4271 or audits@travelers.com

Action is required to avoid an Audit Noncompliance Charge

Dear Customer,

Premium Audit has previously reached out to you to schedule an appointment to conduct a final premium audit of your workers compensation policy referenced above. At the time of this letter, you have not met with an auditor or provided all the information and documents necessary to complete the audit and therefore you are considered noncompliant.

Audit Noncompliance

We care about you and your business. In order to avoid the assessment of an Audit Noncompliance Charge, you must act quickly to provide the requested information. If the requested information is not received, an Audit Noncompliance Charge in the amount of **\$306,394** may be applied to your premium as outlined by the Audit Noncompliance Charge Endorsement outlined in your policy.

Visit travelers.com/audit for answers to frequently asked questions regarding Audit Noncompliance.

Getting Started

If you need to logon as a new user you can do that by going to www.travelers.com/register/biz.

Information Needed to Comply

To comply with your premium audit, please immediately provide us with the requested audit documents. If submitting online, specific documents will be requested based upon your type of policy. Visit travelers.com/audit for frequently asked questions regarding Audit Noncompliance and Required Documents Checklists (note: this may be a different site from where you are directed to register).

- **Payroll information.** Match as closely to your Workers Compensation policy period as possible. For payroll reports include owners, officers and employees and their job duties for proper classification. You can round to the first of the month (it is acceptable to deviate from the policy period by 30 days).
- **Tax Forms.** Federal Form 941 and/or State Unemployment Wage Reports (SUTA). If your quarterly tax reports don't line up with your policy term, simply provide your last four filed quarterly reports. If you have policy coverage in California, DE-9 forms are required.
- **Contracted Labor.** If you utilized non-employee services during the policy term please provide payment information for all contracted and sub-contracted labor used during your audit period and supply a copy of their Certificate of Insurance (if insured).

NOTE: If the tax documents above do not apply to your business, you must provide one of the following:

- For a Sole Proprietor, the Profit or Loss (Form 1040) Schedule C tax form, pages 1 and 2
- For a Partnership, U.S. Partnership Return of Income (Form 1065) Page 1 and 1125-A
- For a Corporation, U.S. Corporation Income Tax Return (Form 1120) Page 1 and 1125-A

Your information is strictly confidential and will be used only for the purpose of completing your audit.

Submit Your Information Online

Register and/or login using the information at the top of the first page of this letter. Documents can be securely uploaded from your computer in a variety of formats and organizing them ahead of time can expedite your online experience. Once your information has been received and reviewed, your Premium Auditor will email you a summary and offer to review your audit findings over the phone and answer any questions you may have.

Don't Have Electronic Documents or a Scanner?

Here are some options:

- **Use your smart device.** Use a scanner app and convert your paper document to PDF format or take pictures of your documents, email them to your computer and upload to the secure site.
- **Fax your documents.** Log into the Premium Audit site and print a bar-coded fax cover sheet which associates your documents to your policy (cover sheets found under "Access Supporting Documents") and fax to: 855-298-6616.
- **Mail your documents.** Send documents to: Travelers Premium Audit, PO Box 2927, Hartford, CT 06104-2927. Please allow additional time for mailing and processing.

Please Let Us Help You

If you need help or are unclear about the information needed for your audit, a Premium Audit Customer Service representative is available to assist you Monday - Friday 8am - 7pm EST at 1-800-842-4271.

Thank you. We appreciate your time and assistance to complete your premium audit.

Sincerely,
The Travelers Premium Audit Team



PREMIUM ADJUSTMENT NOTICE

TRAVELERS - RMD
P.O. BOX 5600
HARTFORD, CT 06102-5600

POLICY NO: 6JUB 4N426077

ISSUE OFFICE:775

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE, GA 30043

DATE OF THIS NOTICE: 11/17/21

SAI #: 2929E3213

POLICY PERIOD: 06/15/21 TO 06/15/22
CANCELATION AUDIT 06/15/21 TO 10/06/21
ESTIMATED UNCOOPERATIVE

72PXX
FOSTER AND ASSOCIATES
3100 BRECKINRIDGE BLVD STE 510
DULUTH, GA 30096-7507

AUDITED RESULTS : \$	47,949
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CUSTOMER SERVICE: (800) 842-4271

*** THIS IS NOT A BILL. SEE MESSAGE
LEGEND ATTACHED. ***

*(THIS IS NOT A BILL)
CALCULATION OF EARNED PREMIUM

Classifications	Tr Cd	Exposure Basis	Rate	Earned Premium/ Charge
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LOCATION 001

PRIME PAINTERS LLC

PAINTING NOC & SHOP OPERATIONS, DRIVERS	5474	132,416	35.7600	47,352
EMPL. LIAB. INCREASED LIMITS		47,352	.0110	521
EXPENSE CONSTANT				50
TERRORISM		132,416	.0100	13
CAT-OTHER THAN CERT TERR 9741		132,416	.0100	13
TOTAL PREMIUM LOCATION 001				\$47,949

TOTAL EARNED PREMIUM \$47,949

Insuring Company:
TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Thank You For Insuring With Our Company



EXPOSURE COMPARISON

INSURED:
PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE, GA 30043

POLICY NO: 6JUB 4N426077
POLICY PERIOD: 06/15/21 TO 06/15/22

DATE OF THIS NOTICE: 11/17/21

The following is a comparison of the estimated exposures on your policy and the actual exposures found at audit.

Classifications		Your Payroll Estimates	Audited Payroll Result	Difference
GEORGIA LOCATION 001 01 PRIME PAINTERS LLC				
PAINTING NOC & SHOP OPERATIONS, DRIVERS	5474	423069	132416	-290653
TOTAL PAYROLL GEORGIA	\$	423,069	132,416	-290,653



MESSAGE LEGEND

MESSAGE LEGEND

THIS IS NOT A BILL. A SEPARATE STATEMENT WILL FOLLOW BASED ON PREMIUMS YOU HAVE PAID

This notice is to advise you of your policy's final premium for the indicated period. If this amount is greater than what you have paid to date, you will be receiving a separate bill for the difference shortly. If you have already paid more than the final premium, you will soon receive a refund of any overpayment.

Questions regarding your policy billing or service can be directed to:

Orlando, Florida

1-800-443-4404

We have made several attempts to obtain payroll and classification information from you in order to prepare the final audit for this workers compensation policy, but you have failed to provide access to those records.

Therefore, we have estimated the final policy premium and are billing you based on the information shown in this Premium Adjustment Notice.

The Audit Provision of your policy contract, requires that you allow us, when requested, to examine and audit records of information needed to compute premium. Please contact us if you misunderstood this requirement and would like to provide those records.

We reserve the right to bill you in the future for any additional premium that might be due under the policy when the necessary payroll and classification information is provided to us.

Should you have any questions, or wish to provide access to the necessary records, please contact us at the telephone number listed on page 1 of this Notice.



COMMISSION INFORMATION

INSURED:
PRIME PAINTERS LLC
1924 A COLLINS HILL RD

POLICY NO: 6JUB 4N426077

DATE OF THIS NOTICE: 11/17/21

The amounts and commission below indicate how premium is to be paid. When the company is paying non resident brokerage fees, commission rates have been reduced accordingly. When the company is paying counter signature fees, reductions have been shown separately.

Account Month	Premium /Charge	Commission Rate	Item
11/21	999	.0800	PREMIUM
	4,000	.0500	PREMIUM
	42,950	.0300	PREMIUM

TRAVELERSTRAVELERS - RMD
P.O. BOX 5600

HARTFORD CT 06102-5600

EARNED PREMIUM

Account No. 2929E3213
 Policy No. 4N426077 UB 00
 Pol. Eff. Date: 06/15/21-10/06/21
 Issue Date: 11/19/21

PRIME PAINTERS LLC
 1924 A COLLINS HILL RD
 LAWRENCEVILLE GA 30043

DIRECT INQUIRIES TO:
 TRAVELERS
 P.O. Box 5600
 Hartford CT 06102-5600
 (800) 443-4404

Insuring Company: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

This bill includes an additional amount as a result of recent audit activity for policy number 4N426077 UB effective 06/15/21 - 10/06/21. This amount is due and payable upon receipt of this notice.

If you have questions concerning this statement please contact your account manager at the phone number provided on this statement.

This statement provides billing information about this specific policy and DOES NOT replace your most recent bill.

If you dispute any of the amount due on this bill, you must do the following by the due date in order to avoid cancellation procedures from being initiated.

- 1) Provide to us written documentation outlining and explaining the specific areas of dispute as well as your estimate of the undisputed amount due and your method of calculation. You must pay the undisputed amount by the "due date".
- 2) Make a written request to the plan administrator for a hearing on the dispute. You may contact us in writing for the name of the plan administrator in your state.

If you are paying with a check from a Personal Checking Account, you authorize us to either use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check. If you are paying with a check from a Business Checking account, we will process the payment as a check.

TO ENSURE PAYMENT IS PROPERLY APPLIED, detach the return payment stub and mail to the return address below..
 ASSIGNED RISK WORKERS COMPENSATION INSURANCE

648842I 2021323 0128 775 072PKX

Payment Coupon Make checks payable to: Travelers

FOSTER AND ASSOCIATES
 PRIME PAINTERS LLC

2929E3213

Travelers
 Dept. 98699
 PO Box 660333
 Dallas, TX 75266-0333

Include Account Number on the check.

☐

Change of Address?
 Place an "X" here.
 Print changes on reverse side.

PAYMENT MUST BE RECEIVED BY
DECEMBER 09, 2021

TOTAL BALANCE
\$46,329.00
MINIMUM DUE
\$46,329.00
AMOUNT ENCLOSED



E

93341434323630373720777772021120900463290000000000000009869900000220097

VIEWING AND PAYING YOUR RESIDUAL MARKET BILL IS NOW EASIER. . .

We understand that paying bills should not be a burden. Our new-look bill includes the following enhancements to make managing your bills easy:

- If you have more than one policy actively billing at the same time, a total balance for all Residual Market Workers Compensation policies is displayed on your bill.
- The "Transactions Since Last Statement" list in the new "Transaction Detail" section provides you with up-to-date details on any premium-bearing changes to your account.
- The change of address box allows you to communicate changes to us without having to pick up the phone.

Paying your bill is even easier.

Our new Voice Response Unit (VRU) allows you to:

- Instantly pay your bill over the phone at no additional cost to you.
- Obtain account information such as minimum due, balance due, and the date your last payment was received.
- Request additional account information.

VRU contact information is provided on your bill.

TRAVELERSTRAVELERS - RMD
P.O. BOX 5600

HARTFORD CT 06102-5600

EARNED PREMIUM

Account No. 2929E3213
 Policy No. 4N426077 UB 00
 Pol. Eff. Date: 06/15/21-10/06/21
 Issue Date: 12/20/21

PRIME PAINTERS LLC
 1924 A COLLINS HILL RD
 LAWRENCEVILLE GA 30043

DIRECT INQUIRIES TO:
 TRAVELERS
 P.O. Box 5600
 Hartford CT 06102-5600
 (800) 443-4404

Insuring Company: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

This bill includes an additional amount as a result of recent audit activity for policy number 4N426077 UB effective 06/15/21 - 10/06/21. This amount is due and payable upon receipt of this notice.

If you have questions concerning this statement please contact your account manager at the phone number provided on this statement.

This statement provides billing information about this specific policy and DOES NOT replace your most recent bill.

If you dispute any of the amount due on this bill, you must do the following by the due date in order to avoid cancellation procedures from being initiated.

- 1) Provide to us written documentation outlining and explaining the specific areas of dispute as well as your estimate of the undisputed amount due and your method of calculation. You must pay the undisputed amount by the "due date".
- 2) Make a written request to the plan administrator for a hearing on the dispute. You may contact us in writing for the name of the plan administrator in your state.

If you are paying with a check from a Personal Checking Account, you authorize us to either use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check. If you are paying with a check from a Business Checking account, we will process the payment as a check.

TO ENSURE PAYMENT IS PROPERLY APPLIED, detach the return payment stub and mail to the return address below.
 ASSIGNED RISK WORKERS COMPENSATION INSURANCE

648842I 2021354 0147 775 072PKX

Payment Coupon Make checks payable to: TravelersFOSTER AND ASSOCIATES
PRIME PAINTERS LLC

2929E3213

Travelers
 Dept. 98699
 PO Box 660333
 Dallas, TX 75266-0333

Include Account Number on the check.

☐

Change of Address?
 Place an "X" here.
 Print changes on reverse side.

PAYMENT MUST BE RECEIVED BY
JANUARY 04, 2022

TOTAL BALANCE
\$46,329.00
MINIMUM DUE
\$46,329.00
AMOUNT ENCLOSED



E

93341434323630373720777772022010400463290000000000000009869900000220020

CLDRESAU



PREMIUM ADJUSTMENT NOTICE

TRAVELERS - RMD
P.O. BOX 5600
HARTFORD, CT 06102-5600

POLICY NO: 6JUB 4N426077

ISSUE OFFICE:775

PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE, GA 30043

DATE OF THIS NOTICE: 01/26/22

SAI #: 2929E3213

POLICY PERIOD: 06/15/21 TO 06/15/22
CANCELATION AUDIT 06/15/21 TO 10/06/21
ESTIMATED UNCOOPERATIVE

72PXX
FOSTER AND ASSOCIATES
3100 BRECKINRIDGE BLVD STE 510
DULUTH, GA 30096-7507

AUDITED RESULTS : \$ 459,261

CUSTOMER SERVICE: (800) 842-4271

*** THIS IS NOT A BILL. SEE MESSAGE
LEGEND ATTACHED. ***

*(THIS IS NOT A BILL)
CALCULATION OF EARNED PREMIUM

Classifications	Tr Cd	Exposure Basis	Rate	Earned Premium/ Charge
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LOCATION 001

PRIME PAINTERS LLC

PAINTING NOC & SHOP OPERATIONS, DRIVERS	5474	423,069	35.7600	151,289
EMPL. LIAB. INCREASED LIMITS		151,289	.0110	1,664
EXPENSE CONSTANT				50
TERRORISM		423,069	.0100	42
CAT-OTHER THAN CERT TERR 9741		423,069	.0100	42
AUDIT NON-COMPLIANCE		153,087	2.0000	306,174
TOTAL PREMIUM LOCATION 001				\$459,261

TOTAL EARNED PREMIUM \$459,261

Insuring Company:

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Thank You For Insuring With Our Company



EXPOSURE COMPARISON

INSURED:
PRIME PAINTERS LLC
1924 A COLLINS HILL RD
LAWRENCEVILLE, GA 30043

POLICY NO: 6JUB 4N426077
POLICY PERIOD: 06/15/21 TO 06/15/22

DATE OF THIS NOTICE: 01/26/22

The following is a comparison of the estimated exposures on your policy and the actual exposures found at audit.

Classifications		Your Payroll Estimates	Audited Payroll Result	Difference
GEORGIA				
LOCATION 001 01				
PRIME PAINTERS LLC				
PAINTING NOC & SHOP OPERATIONS, DRIVERS	5474	423069	423069	0
TOTAL PAYROLL GEORGIA	\$	423,069	423,069	



MESSAGE LEGEND

MESSAGE LEGEND

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This notice is to advise you of your policy's final premium for the indicated period. If this amount is greater than what you have paid to date, you will be receiving a separate bill for the difference shortly. If you have already paid more than the final premium, you will soon receive a refund of any overpayment.

Questions regarding your policy billing or service can be directed to:

Orlando, Florida

1-800-443-4404

We have made several attempts to obtain payroll and classification information from you in order to prepare the final audit for this workers compensation policy, but you have failed to provide access to those records.

Therefore, we have estimated the final policy premium and are billing you based on the information shown in this Premium Adjustment Notice.

The Audit Provision of your policy contract, requires that you allow us, when requested, to examine and audit records of information needed to compute premium. Please contact us if you misunderstood this requirement and would like to provide those records.

We reserve the right to bill you in the future for any additional premium that might be due under the policy when the necessary payroll and classification information is provided to us.

Should you have any questions, or wish to provide access to the necessary records, please contact us at the telephone number listed on page 1 of this Notice.



COMMISSION INFORMATION

INSURED:
PRIME PAINTERS LLC
1924 A COLLINS HILL RD

POLICY NO: 6JUB 4N426077

DATE OF THIS NOTICE: 01/26/22

The amounts and commission below indicate how premium is to be paid. When the company is paying non resident brokerage fees, commission rates have been reduced accordingly. When the company is paying counter signature fees, reductions have been shown separately.

Account Month	Premium /Charge	Commission Rate	Item
02/22	999	.0800	PREMIUM
	3,999	.0500	PREMIUM
	94,998	.0300	PREMIUM
	53,091	.0200	PREMIUM
	306,174	.0000	PREMIUM